

two subsequent prescriptions. Time to discontinuation was analyzed using Kaplan-Meier and Cox proportional hazards regression, including demographic, treatment background, and diabetes-related complications/comorbidities as covariates. **RESULTS:** 66,206 patients (mean age 52.6 years; 50% male; median/maximum follow-up, 10.1/19.0 months) were identified in the Truven database. After one year, the percentage of patients still on treatment was significantly higher with canagliflozin 100 mg (n=7,445; 64.0%) and 300 mg (n=4,486; 65.0%) versus DPP-4 inhibitors (30.2% [linagliptin] to 50.1% [sitagliptin]) and GLP-1 agonists (24.3% [exenatide] to 43.0% [liraglutide]) (P <0.0001 for all comparisons). The adjusted hazard ratio (HR) for time to discontinuation for canagliflozin 100 mg (reference) and 300 mg (HR=0.92 [0.86;0.99]) was significantly lower versus DPP-4 inhibitors and GLP-1 agonists: sitagliptin (n=29,426; HR=1.28 [1.22;1.34]); saxagliptin (n=1,566; HR=2.01 [1.86;2.16]); linagliptin (n=1,432; HR=2.08 [1.92;2.24]); exenatide (n=2,376; HR=2.59 [2.41;2.77]); exenatide long-acting (n=5,922; HR=1.46 [1.40;1.52]); liraglutide (n=17,690; HR=1.23 [1.20;1.27]). Being younger, male, and being on monotherapy were associated with higher discontinuation risk. HRs were stable across sensitivity analyses using alternative discontinuation definitions. Analyses from Optum were generally consistent with these results. **CONCLUSIONS:** These analyses indicate that patients who received canagliflozin versus DPP-4 inhibitors or GLP-1 agonists remained on their therapy longer, which may reflect better effectiveness and/or tolerability.

PDB92

CURRENT REAL-WORLD PRESCRIBING PATTERNS IN TYPE 2 DIABETES MELLITUS: WHAT COMES AFTER METFORMIN? EVIDENCE FROM U.S. INTEGRATED DELIVERY NETWORKS

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OBJECTIVES: Within the US type 2 diabetes mellitus (T2DM) treatment, following metformin failure, is thought to be quite variable given a broad treatment armamentarium. We therefore, sought to determine if newer agent classes or patient age influenced prescribing patterns. **METHODS:** De-identified prescriptions from the T2DM analytic platform of the Humedica electronic health records database were described, 1/1/2010–6/30/2014. **RESULTS:** Selection criteria were met by 193,592 T2DM patients, of whom 71,452 (37%) were ≥65 years-old (“elderly”). Of first-line prescriptions, metformin was the most common (59%) followed by SUs (13%), basal (9%) and other insulins (9%), DPP4s and DPP4 fixed-dose-combinations (5%), GLP1 (2%), TZDs (2%); others <1%. Metformin first-line monotherapy was prescribed to 140,055 patients. Of these, 112,387 (80%) remained on monotherapy or discontinued without receiving subsequent prescriptions, only 20% progressed to a second-line therapy. Top second-line prescriptions were for: metformin+SU (30%), SU monotherapy (16%), metformin+DPP4 (9%), DPP4 monotherapy (6%), metformin+basal insulin (4%), metformin+GLP1 (4%), DPP4 FDC (4%), metformin+other insulin (3%); others <3%. The elderly received first-line prescriptions for: metformin (49%), SU (18%), insulins (basal, 10%; other, 11%), DPP4 FDCs (6%), TZDs (3%), other FDCs (1%), and GLP1s (1%). Of the 42,852 elderly receiving metformin monotherapy, 81% either continued metformin monotherapy or discontinued without receiving subsequent prescriptions, with 19% progressing to second-line. Top second-line prescriptions among the elderly were: metformin+SU (29%), SU monotherapy (22%), metformin+DPP4 (9%), DPP4 monotherapy (8%), metformin+other insulin (4%), metformin+basal insulin (4%), insulin (basal, 3%; other 3%), others <3%. **CONCLUSIONS:** First-line metformin was most commonly prescribed. Interestingly, despite the availability of newer agents classes (e.g., DPP4, GLP1s), most common second-line therapy was SU add-on to metformin or monotherapy. Contrary to popular beliefs, we observed no age-related differences in prescribing patterns. The outcomes and costs of such treatment patterns in the elderly relative to hypoglycemia and its sequelae warrants further evaluation.

PDB93

DOES TREATMENT FOR NEWLY-DIAGNOSED DEPRESSION REDUCE HEALTHCARE EXPENDITURES AMONG MEDICAID BENEFICIARIES WITH TYPE 2 DIABETES MELLITUS?

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OBJECTIVES: To examine whether depression treatment is associated with healthcare expenditures among Medicaid beneficiaries with Type 2 Diabetes Mellitus (T2DM) and newly-diagnosed depression. **METHODS:** A retrospective longitudinal repeated measures cohort design was used. Multi-year (2000–2008) three-state Medicaid data were used. The cohort included non-elderly, fee-for-service, continuously enrolled Medicaid beneficiaries with T2DM and newly-diagnosed depression (N=5,295). The depression diagnosis date was the “index-date”; baseline and follow-up periods were defined as 12-months prior and subsequent to the index-date. Depression treatment received in 120 days after index-date was categorized as, treatment with antidepressants only, psychotherapy only, both antidepressants and psychotherapy and no treatment. Total healthcare expenditures were calculated for each follow-up month. Linear mixed effects regressions on log transformed total expenditures were used to examine associations between depression treatment and monthly healthcare expenditures after adjusting for random intercept and fixed effects of time in months, depression treatment, types of co-existing chronic physical conditions (hierarchically classified based on their similarity to T2DM pathophysiology and/or management into dominant, concordant only, discordant only and both concordant and discordant), gender, age, race/ethnicity, other mental health conditions, Medicaid eligibility due to poverty/medical need/waiver (yes/no), baseline healthcare utilization and county of residence characteristics such as presence of healthcare infrastructure (e.g. community mental health care clinic) and social determinants of health (e.g. county median income). **RESULTS:** Overall, 57% had depression treatment (antidepressants only: 27.3%, psychotherapy only: 18.1% and both: 11.4%). The average yearly expenditures were \$30,590 for

antidepressants only, \$35,099 for psychotherapy only, \$33,032 for both and \$34,041 for those receiving no depression treatment. Adjusted linear mixed model analysis revealed that as compared to no depression treatment, depression treatment with antidepressants only, psychotherapy only and by both antidepressants and psychotherapy reduced total healthcare expenditures by 17% (p-value <0.001), 22% (p-value <0.001) and 28% (p-value <0.001) respectively. **CONCLUSIONS:** Depression treatment reduced healthcare expenditures suggesting that among individuals with T2DM who develop depression, prioritizing treatment for depression can result in economic benefits.

PDB94

EVOLUTION OF THE MARKET FOR ORAL ANTIDIABETIC AGENTS IN CANADA AFTER INTRODUCTION OF DIPEPTIDYL PEPTIDASE-4 INHIBITORS

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OBJECTIVES: Type 2 diabetes mellitus (DM) accounts for over 90% of all diagnosed diabetes cases. Hyperglycemia is an important risk factor for diabetic complications, supporting the use of glucose-lowering agents in the treatment of diabetes. Among glucose-lowering agents to treat type 2 DM are oral antidiabetic (OAD) agents. The objective of this study was to evaluate the Canadian market for OAD agents since 2008, soon after dipeptidyl peptidase (DPP)-4 inhibitors were introduced. **METHODS:** Data on retail prescriptions and on drugstore and hospital purchases of OAD agents in Canada were obtained from IMS Brogan. Number of prescriptions and purchases (in \$Can) were collected for 2008, 2012 and 2014. **RESULTS:** Total number of prescriptions for OAD agents in Canada amounted to 13.6 million, 20.5 million and 23 million in 2008, 2012, and 2014, respectively. Contribution of the two OAD agents mainly prescribed, metformin and sulfonylureas, decreased during this period while percentage of prescriptions for DPP-4 inhibitors over total OAD agents increased from 0.075% to 6.5% and to 14.5%, respectively, driven by the increase in prescriptions of sitagliptin, sitagliptin/metformin, saxagliptin, and linagliptin. Total drugstore and hospital purchases for OAD agents in Canada reached \$394.2 million, \$418.7 million and \$520.9 million in 2008, 2012, and 2014, respectively. Percentage of purchases of DPP-4 inhibitors over total OAD agents markedly increased during this period, from 0.5% to 34.1% and to 64.1%, respectively. **CONCLUSIONS:** OAD agents represent a market of more than half a billion dollars in Canada; this will likely continue to grow due to the increasing occurrence of cases of type 2 DM in the general population. Since their introduction in 2008, DPP-4 inhibitor use has grown rapidly so that in 2014, they captured approximately one-sixth of prescriptions and, at almost two-thirds of purchases, were the market leaders among OAD agents.

PDB95

INFO-DIABETIC APPROACH FROM CELLULAR PHONE TEXT MESSAGING CAN MINIMIZE THE COMPLEXITIES IN DIABETIC PATIENT CARE

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OBJECTIVES: Info-Diabetics’ is becoming an imperative approach in E-health to stipulate the diabetic patient care and management. In this study we tried to get an overview for application of cellular phone text messaging over adolescent diabetic patients (ADPs). The major objective of this study was to test whether adding cellular application for patient care compared with control cases would reduce Glycated Hemoglobin (HbA1c). **METHODS:** Eleven ADPs (study cases, n=11) were selected for mobile phone coaching through text messaging, to consultants. ADPs of the control site (n=09) were continued with their standard diabetes health care from consultants. Primarily ADPs were enquired for demographic and social characteristics, frequency of cellular phone use, general health information and diagnosis of type 2 diabetes. Further the level of Hb1Ac, in both the groups, was measured in a regular interval of 45 days. After 225 days, percentage of mean improvement in Hb1Ac level was compared between cellular users and control cases. **RESULTS:** More than 3% improvement in Hb1Ac was observed among the patients having mobile phone and they made regular interaction with consultant. The differences were very small but a trend of positive improvement was observed among ADPs using cellular phone’s text messaging. **CONCLUSIONS:** Result indicated that info-diabetic approach may contribute to minimize complexities in medical care and the cautious use of cellular phone technology in the form of text messaging would be an asset for self care management in ADPs.

PDB96

FINANCING A CURE FOR DIABETES IN A MULTI-PAYER ENVIRONMENT

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BACKGROUND: In a recent commentary (Basu ERPOR2015), we proposed a solution to financing cures in the presence of multiple payers by recommending development of a tradable new currency, HealthCoin, which would convert the incremental consequences produced by certain well-established cures to a common numeraire that can be traded with real dollars in the marketplace among private and public payers. **OBJECTIVES:** To develop the theory behind the provision of a tradable HealthCoin for a cure for diabetes between a private payer that provides coverage for non-elderly adults, and a public payer (e.g. Medicare) covering the elderly population. **METHODS:** We identify the conditions under which the either payer lacks incentive to pay for the cure and where a HealthCoin can overcome these incentives problems. We illustrate this theory using empirical estimates for cost-savings and life-years gain generated by a cure for diabetes. **RESULTS:** We find that the precise condition required for the valuation of a HealthCoin that would incentivize the public payer to offer the HealthCoin as a payment to the private payer, which in turn would now have the incentive to purchase the cure, is $\min\{NMB, Medicare, PCure\} \geq$

HealthCoin \geq PCure - EINMBNE, Private, where INMBMedicare is the incremental net monetary benefits (INMB) to Medicare of a cure of diabetes for a 65-years old, EINMBNE, Private is the average INMB to the private payer for a cure of diabetes across all non-elderly incident population with diabetes, and PCure is the market price for the cure. Using empirical estimates, we explore whether a developing such a HealthCoin would be feasible. **CONCLUSIONS:** We find, theoretically, that developing such a HealthCoin may be feasible for a cure of diabetes. Extension of this work would explore how such HealthCoins can be traded within the private sector and also in other disease areas.

PDB97

BENEFITS OF BREASTFEEDING ON DEVELOPMENT OF DIABETES MELLITUS, IN WOMEN WITH HISTORY OF GESTATIONAL DIABETES MELLITUS USING THE NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY

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OBJECTIVES: Women with Gestational Diabetes Mellitus (GDM) have six times higher risk of developing Diabetes Mellitus (DM) type 2 compared to women who don't have GDM. The purpose of this study was to evaluate the protective effects of breast-feeding on development of DM in women with GDM. **METHODS:** This was a cross sectional study where a secondary database analysis was done using National Health and Nutrition Examination Survey (NHANES) data 2007-2008, 2009-2010 and 2011-2012. Females 20 to 75 years with at least one live birth were included. Chi-square-test compared differences between categorical variables and t-test examined differences in the means for continuous variables. Unadjusted-odds-ratio was calculated using logistic regression to examine breastfeeding as an effect modifier in the association between GDM and DM. Model was adjusted for age, BMI, race/ethnicity, income, education, age at DM and number of live births. Sample weights and the stratification and clustering of the design were incorporated to obtain proper estimates. **RESULTS:** The final analytic sample consisted of 6503 participants. Percentage of GDM women who breast-fed seemed higher than women without GDM (64.6% vs. 44.9%). Among women who breastfed, the odds ratio for developing DM in women with GDM was 3.3 (95% CI 2.3, 4.9) compared to those without GDM while, in women who never breastfed, the odds ratio was 3.9 (95% CI 2.3, 6.6). After adjusting for age, BMI, race/ethnicity, education and number of live births, OR for the association between DM and GDM was 2.2 (1.4, 3.4) in women who breastfed and 2.8 (1.6, 4.9) in women who didn't breast feed. **CONCLUSIONS:** This analysis found that there's potential benefit of BF in the prevention of DM among women who had GDM. This result adds to the already known important benefits of BF and more women should be encouraged to BF.

PDB98

ASSESSMENT OF A FRENCH ENDOCRINOLOGIST ELECTRONIC MEDICAL RECORD DATABASE FOR USE IN OBSERVATIONAL STUDIES

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OBJECTIVES: Most endocrine disorders are chronic diseases that need life-long care. Some of the most common endocrine diseases include diabetes mellitus, hypothyroidism and metabolic syndrome. Although most of the patients suffering of these diseases are followed by their primary care physician, definite diagnosis, initiation/change of treatment and chronic care of the disease is ensured by the endocrinologist. The objective of this study was to evaluate an endocrinologist electronic medical record (EMR) database to assess its feasibility for use in observational studies. **METHODS:** We analyzed de-identified patient data from Longitudinal Patient Database (LPD) Endocrinologist panel, including endocrinologists from 2013-2014. Comprehensiveness and completeness of each variable by visit was evaluated. Characteristics of physicians and patient population were compared to published sources. **RESULTS:** There were 77 243 visits by 34 492 active patients (= 1 visit per year) to 40 physicians. Completeness of each variable by visit ranked from 100% to 27% for sex, age and laboratory results. Most of these patients (73%) were female. Analysis of diagnosis associated to visits revealed that 32% were related to diabetes, while 32% and 9% were related to thyroid disorders and obesity respectively. Among diabetic patients, 50% were female, and 74% had type 2 diabetes. An average BMI of 30 and HbA1C of 7.4% was recorded. Among treated patients 38% received sulfonylureas and 59% biguanides. A third of the patients (34%) received one, another third (33%) received two, and another third (33%) three or more anti-diabetic treatments (including insulin). Insulin was prescribed, alone or in combination, in 36% of cases. The comparison of these data with literature is presented. **CONCLUSIONS:** This panel is still new and needs further validation studies. Good agreement with published data suggests this may be a valuable tool to support observational studies.

PDB99

PHYSICIAN REPORTED REASONS FOR DISCONTINUING OR DOWN-TITRATING SULFONYLUREAS IN TYPE 2 DIABETES PATIENTS

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OBJECTIVES: Sulfonylureas (SU) are a widely-prescribed class of oral medications used to treat type 2 diabetes mellitus and are known to cause hypoglycemic events (HE) and weight gain. In this survey, we aimed to identify reasons reported by physicians for discontinuing (DC) or down-titrating (DT) SU therapy. **METHODS:** Primary care physicians (PCPs) and specialists (endocrinologists and diabetologists) were recruited from the AllGlobal panel, an actively managed, double opt-in panel of physicians. Participants were asked to rate their level of concern regarding potential reasons for DC or DT on a 7-point Likert scale (1=not at all concerned, 7=extremely concerned). In addition, physicians reviewed one chart each from a typical SU patient with DC or DT in the previous 6 months and 2 current SU patients without DC or DT in the previous 6 months to collect patient characteristics and medical history. **RESULTS:** 776 PCPs and 250 specialists participated, of whom 76% were male and 93% were aged 35 to 64. Physicians reported highest concern about HE

requiring medical assistance (DC=6.0, DT=5.9), HE requiring non-medical assistance (DC=5.9, DT=5.9), other HE not requiring assistance (DT=5.7), and treatment goals not being met (DC=5.6). Compared to current users, DT and DC patients were more likely to have experienced ≥ 1 HE in the previous year (DC=41.0%, DT=43.1% vs. current=8.8%; $p < .05$), and experienced a greater mean number of events per year (DC=1.59, DT=1.47 vs. current=0.24, $p < .05$). Having ≥ 1 HE requiring medical assistance in the previous year was more common among DC patients than DT or current patients (DC=7.4%, DT=4.3%, current=4.8%; $p < .05$). **CONCLUSIONS:** Hypoglycemia and glycemic control emerged as the most important concerns physicians have when deciding to DC or DT SU therapy. DC and DT patients were more likely to have experienced HE, and with greater severity, than current SU patients.

PDB100

USE OF HEDIS A1C TARGETS IN CHARACTERIZING TREATMENT GOALS IN PATIENTS WITH TYPE 2 DIABETES MELLITUS (T2DM) INITIATING BASAL INSULIN

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OBJECTIVES: While change in glycated hemoglobin (A1C) is typically used as the primary measure of efficacy in clinical trials of diabetes medications, quality of care in "real-world" clinical practice is often assessed based on attainment of patient-specific A1C targets, as recommended in HEDIS 2014 performance benchmarks by the National Committee for Quality Assurance. HEDIS measures are used by US health plans to measure care and service performance. To assist in the design of pragmatic clinical trials for new insulin glargine 300 U/ml (Gla-300), we estimated A1C targets for T2DM patients initiating basal insulin in real-world clinical practice, using a large retrospective database and data from a clinical trial. **METHODS:** Insulin-naïve T2DM patients initiating basal insulin were identified in both the Ingenix Impact National Managed Care (IMPACT) database (n=22,428) and EDITION 3 (n=862), a clinical trial of Gla-300. Patients were stratified according to whether they were aged < 65 y and free of selected comorbidities (A1C target $< 7.0\%$), or aged ≥ 65 y and/or with one or more comorbidities (A1C target $< 8.0\%$), according to HEDIS measures. **RESULTS:** In the IMPACT database, mean age was 52y, and mean baseline A1C (SD) was 9.0% (± 2.7) in those with available A1C. Patients aged < 65 y without comorbidities (target $< 7.0\%$) constituted 68.1% of the sample, while 31.9% were aged ≥ 65 y and/or had comorbidities (target $< 8.0\%$). In the EDITION 3 trial, mean age was 58y, and mean baseline A1C (SD) was 8.5% (± 1.1). Patients aged < 65 y without comorbidities (target $< 7.0\%$) constituted 73.0%, and 27.0% were aged ≥ 65 y and/or had comorbidities (target $< 8.0\%$). **CONCLUSIONS:** The distribution of T2DM patients initiating basal insulin by A1C target, based on HEDIS performance measures, was similar in both real-world and clinical trial settings. Findings from trials therefore may be useful in the design of pragmatic clinical trials of Gla-300.

PDB101

EFFECT OF DIABETES EDUCATION PROGRAM ON TYPE 2 DIABETES

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OBJECTIVES: The aim of the study was to measure the effect of diabetes educational program on type 2 diabetic patients. **METHODS:** In total, a convenient sample of 215 patients were attended a group-based educational intervention session about diabetes which is conducted by a researcher. Knowledge evaluation questionnaire were evaluated at pre and post test. Anthropometric measurements and lab tests were measured at pre and post test. Significance of the results was assessed by paired t-test at 95% confidence interval using SPSS version 16. **RESULTS:** BMI was decreased significantly after educational intervention, (from 32.1 \pm 5.76 to 31.23 \pm 5.8) ($p = 0.000$). Moreover, a significant decrease in glycosylated hemoglobin after educational intervention were reported, (from 8.57 \pm 1.21 to 7.95 \pm 1.42) ($p = 0.000$). A significant increase in knowledge evaluation test scores were shown after educational intervention (from 60.6 \pm 20.65 increased to 78.1 \pm 13.4) ($p = 0.000$). **CONCLUSIONS:** Diabetes education is a cornerstone in the management and care of diabetes and should be an integral part of health planning involving patient's family, diabetes care team, community and decision makers in the education process. **Key Words** Diabetes, Educational, Program, Intervention.

PDB102

CHANGES IN BASELINE COMORBIDITIES, MEDICATIONS AND HEALTHCARE COSTS FOR A POPULATION OF PATIENTS WITH NEW-ONSET TYPE 2 DIABETES (T2D) IN 2007 COMPARED WITH 2012

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OBJECTIVES: It is important to understand diabetes treatment patterns over time. This study compared changes in comorbidities, treatment patterns, and costs among newly-diagnosed T2D patients in 2007 and 2012. **METHODS:** Separate cross-sectional analyses of medical treatments, diagnoses, and pharmacy claims in the Truven Health MarketScan® Database were conducted for 2007 and 2012. Criteria for newly-diagnosed T2D were enrolment 6 months prior to index, ≥ 2 diagnoses for T2D (ICD-9 codes), ≥ 18 years old, and continuous enrolment in a plan with prescription benefits for ≥ 1 year. **RESULTS:** Comparing 2007 with 2012, T2D incidence rate decreased from 1.1% to 0.65% of all enrolled patients. Hyperlipidemia (46% and 57%) and hypertension (55% and 62%) were the 2 most prevalent comorbidities. 46% and 57% of patients in 2007 and 2012 used only oral anti-diabetic drugs (OADs). Single OAD use increased from 68% to 77% of these patients. Metformin (Met) was the most prevalent OAD monotherapy, amounting to 75% and 90% of single OAD prescriptions. SU monotherapy fell from 14% to 6%. Met+SU, the most widely used dual OAD combination, grew from 48% to 57% of dual users. Met+T2D use fell from 30% to 0%, replaced by Met+DPP-IV (34%). An insulin-only regimen was used by 1.4% and 1.6% of patients for 2007 and 2012, and insulin+OADs were used by 2.5% and 3.7% of patients, respectively. Basal