tion, but 76.2% thought that the objective was to control pharmaceutical spending. Most PCP's (87.1%) declared that their prescribing criteria provided enough control and that mechanisms such as IVP are not necessary in medicines used in prevalent chronic diseases managed in primary care such as T2DM, hence, 75.4% of PCP's support their withdrawal. **CONCLUSIONS:** PCP's believe that clinical criteria are enough to decide on the appropriate treatment for T2DM, and that other control mechanisms such as IVP are mainly focused on cost containment purposes.

PDB29

THERAPY CHANGE AND PROGRESSION TO INSULIN USE AMONG TYPE-2 DIABETIC PATIENTS NEWLY TREATED WITH SULFONYLUREA (SU) OR METFORMIN (MF) MONOTHERAPY

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OBJECTIVES: To assess therapy change, discontinuation, and insulin use among type-2 diabetic patients newly treated with metformin (MF) or sulfonylurea (SU) monotherapy. **METHODS:** Type-2 diabetic patients ≥30 years old who started MF or SU monotherapy from January, 1997 to November, 2000 and had not received any hypoglycemic agents (HAs) within one year prior to therapy initiation were identified from a UK general practice (GP) database. At least one subsequent prescription of HAs within one year after monotherapy initiation was required for inclusion. Cox proportional hazards model, adjusted for baseline patient characteristics and co-morbid conditions, was used to estimate the likelihood of initiating insulin. **RESULTS:** Among the 3857 eligible patients, 59.4% (40.4%) of them started with SU (MF) monotherapy. For the SU (MF) group, 57.6% (50.8%) of them were male and the mean age was 67.5 (63.0) years. Those receiving MF were more likely to be women (49.1% vs. 42.4%, $p < 0.001$), obese (16.2% vs. 6.70%, $p < 0.001$) and with dyslipidemia (28.5% vs. 23.8%, $p < 0.001$). Mean duration of follow-up for the SU (MF) group was 25.1 (24.6) months. Therapy change was found in 19% (27%), whereas therapy discontinuation was found in 24% (18%) of the SU (MF)—treated patients. Initiation of insulin were 10.7% (95%CI: 9.05%–12.4%) and 8.80% (95%CI: 6.76%–10.8%) for the SU and MF groups, respectively. After controlling for confounders, the MF group had a lower hazard of initiating insulin (Adjusted Hazard Ratio = 0.58, 95%CI: 0.45–0.75) compared to the SU group. **CONCLUSIONS:** In this cohort of type-2 diabetic patients managed by GP's in the UK who were newly treated with MF or SU monotherapy, therapy change and discontinuation were common within a year. Almost 10% of them initiated insulin during the average of a 2 year follow-up period.

PDB30

DRUG UTILIZATION OF GLITAZONES IN ITALY

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OBJECTIVES: People suffering from type-2 diabetes who fail on monotherapy with metformin or sulphonylurea should receive glitazones instead of injective insulin. Patients report a poor preference for insuline treatment because of its burden on their quality of life. Glitazones could represent a more appropriate treatment for them. Nowadays in Italy, glitazones are approved for hospital use only. We describe the drug utilization of glitazones (rosiglitazone and pioglitazone), and relationship with their potential use. **METHODS:** The expected number of type-2 diabetic patients who could be treated with glitazones was calculated analyzing a large database of diabetic patients. Patient candidates for glitazones were those with an unsatisfactory glycaemic control using metformin or sulphonylurea, given at the highest dose tolerated by patients, obese (BMI > 30), with haemoglobin A1c > 8%), without heart failure and liver diseases. We obtained IMS Health data on sales of glitazones in Italy during 2003 (365 days). These data were turned into Defined Daily Dose (DDD)/1000 inhabitants day, by means the formula: distributed DDD/(population × reference days) × 1000. **RESULTS:** The number of patients eligible for treatment with glitazones was about 23,000. The expected use of glitazones (to treat all eligible patients) was 0.4025 DDD/1000 inhab. day. During the evaluated period, 0.0507 DDD/1000 inhab. day of rosiglitazone and 0.0257 DDD/1000 inhab. day of pioglitazone were distributed. Altogether, 0.0764 DDD/1000 inhab. day were used in Italy. **CONCLUSIONS:** Distributed glitazones can treat about 19% of eligible diabetic patients. The reasons of this poor use could be the availability of glitazones only through the hospital, and the limitation of hospital expenditure for drugs. Eligible patients who do not receive glitazones risk being treated with injective insuline, with a negative burden on their quality of life.

PDB31

COMPARISON OF BLOOD PRESSURE AND ATTRIBUTABLE HEALTHCARE COSTS BY DIHYDROPYRIDINE VS NONDIHYDROPYRIDINE CALCIUM CHANNEL BLOCKER INITIATED FOR HYPERTENSION IN DIABETES MELLITUS PATIENTS, AND MONITORING OF RENAL PARAMETERS

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The JNC-7 and ADA recommend a goal BP of <130/80 mmHg in diabetes mellitus (DM) patients. Clinical trials suggest most DM patients require ≥2 antihypertensive medications to achieve BP goal. **OBJECTIVES:** Compare differences in BP and healthcare costs by CCB type (dihydropyridine [DHP] vs. (nondihydropyridine [NDHP]) added to an antihypertensive regimen. Proportion of patients tested for proteinuria was also assessed. **METHODS:** Administrative claims data were obtained from Western and Southeastern US health plans. Patients were identified (N = 5551) with DM and HTN initiated on CCB therapy from January 1, 2000 through June 30, 2002, with eligibility 6 months prior and 1 year post-index, no CCB prescriptions within 6 months pre-index date, and medication possession ratio >50% in the 1 year post-index period. Costs attributable to DM or HTN were analyzed. A random sample was targeted for medical chart review. Testing for proteinuria was identified from both claims and medical charts. **RESULTS:** Majority of patients initiated on CCB received other antihypertensive medications; 86% and 76% in the DHP and NDHP groups, respectively. The NDHP group had lower annual attributable costs ($1637 [95% CI, $1479–$1813] vs. $1989 [95% CI, $1823–$2170]; $P < 0.004$). A total of 313 medical charts were reviewed (DHP = 242, NDHP = 71). Both groups had similar pre- and post-index BP values; mean changes in SBP and DBP were not statistically significant between groups. Percentages of patients achieving BP goal were low in both groups; <25% achieved SBP goal of <130 mmHg, and 36%–37% achieved DBP goal of <80 mmHg. Less than 45% of patients were tested for proteinuria during the study period. **CONCLUSIONS:** Patients initiated on an NDHP attained similar BP reductions compared to DHP at lower total costs. Opportunities exist for more aggressive management of BP and testing for proteinuria in DM patients with HTN.