comes from BOT (insulin glargine plus glimepiride and metformine) in comparison to a conventional therapy (CT) with pre-mixed insulin (30/70) twice daily were analysed. METHODS: The applied DMM is an epidemiological simulation model developed to predict the progression of the disease in a simulated diabetes patient population. Baseline values for the simulations: mean age of the population 60 ± 9.0 years, mean duration of diabetes 9.0 ± 7.0 years and mean HbA1c value 8.8 ± 0.9%. The response rate for BOT (HbA1c ≤ 7%) was 49% and for CT 39%. Mean HbA1c for responders were 6.46% and 6.55% respectively, whereas values for non-responders were assumed to be 7.82% and 8.09%. The responder rates in the sensitivity analyses were varied in 2%-steps, with a range between 44% and 56%. Additionally the impact of age/duration variations was analysed. RESULTS: The relative risk reduction (ERR) for micro vascular events after 10 simulation years for BOT versus CT cohort varied between 14% (ESRD) and 2% (retinopathy). The sensitivity analysis showed that also with a worst-case scenario (i.e. BOT responder-rate of 44%) the ERR for ESRD was still in the range of 10%. Patient stratification on age and duration demonstrated that the response-rates had the strongest influence on diabetes complications of kidneys and nerve system, especially in the earlier stages of diabetes. CONCLUSIONS: Better HbA1c control with BOT compared to CT is estimated to reduce long-term micro-vascular complications based on simulations with the DMM.

**PDB2**

AN EVALUATION OF DIABETES CONTROL AND REPORTS OF HYPOGLYCAEMIA IN UK GENERAL PRACTICE FOLLOWING INITIATION OF INSULIN GLARGINE VERSUS INSULIN DETEMIR USING OBSERVATIONAL, REAL-LIFE DATA

Currie CJ1, Tewit AP2, Holmes P1, Poole CD3, McEwan P3

1Cardiff University, Cardiff, South Glamorgan, UK, 2Cardiff Research Consortium, Cardiff, South Glamorgan, UK, 3sanofei-aventis UK, Guildford, Surrey, UK

OBJECTIVES: The purpose of this study was to measure the relative outcome of treatment following initiation of treatment with insulin glargine versus insulin detemir in General Practice in people with both type 1 (T1DM) and type 2 (T2DM) diabetes mellitus. METHODS: Data were extracted from a proprietary database of primary care records (THIN). Cases were selected if treated exclusively with either glargine or detemir. Glycaemic control (HbA1c) was extracted for up to nine months following switching when treated with glargine; the mean reduction in HbA1c using detemir groups respectively: 61.4 years vs. 58.6 years old, 10.3 years vs. 9.0 years diabetes duration, 46.0% female vs. 45.9% female, 20.2 kg/m2 BMI vs. 31.0 kg/m2. The HbA1c deterioration profile was very similar prior to switching to either treatment. Following switching, diabetes control was superior in T1DM subjects available for analysis in the glargine group and 528 sub-

**PDB3**

THE COST-BENEFIT OF KERRABOOT USE IN DIABETIC FOOT ULCER MANAGEMENT

Knight AD1, Sexton O2

1Evicomp Ltd, Twickenham, Middlesex, UK, 2Ark Therapeutics Group plc, London, Middlesex, UK

OBJECTIVES: The Kerraboot is a non-pressurized boot-like dressing designed to provide an environment for improved healing without the need for conventional dressings and which can be more readily replaced by the healthcare professional or patient. The cost benefit of this product compared to conventional dressing management was investigated. METHODS: A cost model based on published costs for conventional dressing treatment was developed and the costs of conventional dressings versus the Kerraboot compared for different grades of diabetic foot ulcers, excluding those that require surgical revascularization. Sensitivity analyses were performed for different treatment regimens, reduced nursing requirements as a result of increased patient self-dressing, use of longer intervals between dressing changes, differing dressing types and dressing costs. RESULTS: Use of the Kerraboot compared to conventional dressings saves nursing time resulting in a reduction in nursing costs of 29–76% per dressing change. Use of the Kerraboot results in overall labour cost savings per patient of ~181% (£516 v £184 – Ulcer grade; Level 1), 15% (£990 v £1139 – Level 2), and 48% (£3805 v £7300 – Level 3) compared to standard conventional dressing. Assessment of Kerraboot use across all levels weighted by severity incidence results in labour cost savings. Patient benefits such as convenience and improved social acceptance have not been costed. CONCLUSIONS: Modelling the variable labour costs of treating diabetic foot ulcers with the Kerraboot versus conventional dressings demonstrates that overall costs will be reduced with the Kerraboot. The greatest saving is seen with level 3 ulcer management. Indirect costs provide further savings.

**PDB4**

AN EVALUATION OF THE COST OF DIABETES-RELATED MEDICATION FOLLOWING INITIATION OF TREATMENT WITH INSULIN GLARGINE VERSUS INSULIN DETEMIR IN THE UK FROM OBSERVATIONAL, REAL-LIFE DATA FROM GENERAL PRACTICE

Poole CD1, Tewit AP1, Holmes P1, McEwan P1, Currie CJ1

1Cardiff Research Consortium, Cardiff, South Glamorgan, UK, 2sanofi-aventis UK, Guildford, Surrey, UK, 3Cardiff University, Cardiff, South Glamorgan, UK

OBJECTIVES: The purpose of this study was to evaluate the relative financial costs associated with the use of insulin glargine versus insulin detemir in routine primary care clinical practice in the UK using real-life, observational data. METHODS: Prescription data was extracted from a proprietary primary care data source, The Health Improvement Network (THIN). Basal analogue-naive patients with at least six months prior history were selected if initiated on either glargine or detemir exclusively in the study period. All diabetes-related prescriptions, between and including the first and last recorded prescription dates for glargine or detemir were analysed. These dates defined the known exposure to either insulin. Medical diagnoses analysis classified cases as having either Type 1 or Type 2 diabetes mel-