

Preventable Diabetes-Related Hospitalizations Drop

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SAN DIEGO — The rate of diabetes-related, potentially preventable hospitalizations in the United States fell by 35% between 1994 and 2002, Michael M. Engelgau, M.D., reported at a press briefing during the annual scientific sessions of the American Diabetes Association.

The rate of hospitalizations refers to the number of admissions per total number of people with diabetes in the United States.

Although the exact cause of the reduction was not studied, the declines in hospitalizations "are representative of good care," said Dr. Engelgau, associate director for prevention policy in the division of diabetes translation at the Centers for Disease Control and Prevention.

"This could be [because] the diabetic population is growing very quickly in the United States," he suggested. "Maybe it's a slightly healthier population [with diabetes that] doesn't need hospitalization quite as much. Or there could be changes in some of the hospitalization practices in the various health care systems in the United States. Some of these factors are coming into play. We can't say exactly how important those are, but the bottom line is that this does seem to be a very positive trend in these types of potentially preventable hospitalizations."

To study the number of preventable

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procedure-related MI, and 3.1% vs. 2.3% for fatal or nonfatal stroke.

In the diabetic participants, similar patterns were also seen for secondary event rates and clearly illustrated that having diabetes increases vascular disease risks across the board: The proportions experiencing any cardiovascular event, for example, were 44.1% of the diabetics with 10-mg atorvastatin and 39.8% of those taking 80 mg, compared with 33.5% and 28.1%, respectively, for the nondiabetics.

Peripheral arterial disease occurred in 8.9% vs. 9.1% of the diabetics, compared with 5.6% and 5.5% of the nondiabetics.

Current guidelines from the National Cholesterol Education Program, which consider diabetes a coronary risk equivalent, advise an LDL cholesterol level below 100 mg/dL for all diabetic patients.

An NCEP update published last year suggested that in patients at very high risk, including those with "multiple major risk factors (especially diabetes)," an LDL target of less than 70 mg/dL might be considered as a therapeutic option (Circulation 2004;110:227-39).

There were no differences in treatment-related side effects between the 10-mg and 80-mg diabetic groups.

Treatment-related myalgia occurred in 3.6% of the 10-mg group and 2.4% of those taking 80 mg, while persistent liver-enzyme elevations three times the upper limit of normal occurred in 0.4% vs. 0.8%, respectively. No cases of rhabdomyolysis occurred in any patient throughout the 5 study years. ■

hospitalizations, Dr. Engelgau and his associates used the Healthcare Cost and Utilization Project National Inpatient Sample from 1994-2002. This sample consists of about 80% of hospitalizations in 35 states and is weighted to represent the nation.

The researchers zeroed in on four conditions that can be avoided with high-quality outpatient care, or can be less severe if treated early and correctly: uncontrolled diabetes, short-term complications such as diabetic ketoacidosis, long-term com-

plications such as chronic kidney disease, and lower extremity amputations.

Between 1994 and 2002, the number of diabetes-related preventable hospitalizations in the United States increased from 439,000 in 1994 to 473,000 in 2002. Total costs for the hospitalizations increased from \$4 billion in 1994 to \$9.5 billion in 2002.

During the same time, people diagnosed with diabetes increased from 8.1 million in 1994 to 13.3 million in 2002. As a result, the rate of diabetes-related preventable hospi-

tal admissions decreased from 55 per 1,000 people with diabetes to 36 per 1,000 people with diabetes, a decline of 35%.

Of the four diabetes-related conditions studied, admission rates for uncontrolled diabetes had the largest decline, from 10 per 1,000 people with diabetes in 1994 to 4 per 1,000 in 2002. The hospital admission rate for long-term complications also had a large decline, from 28 per 1,000 people with diabetes in 1994 to 20 per 1,000 in 2002. ■

The starting and maintenance dose for MOBIC is 7.5 mg once daily. Some patients may receive additional benefit by increasing the dose to 15 mg once daily. Higher doses of MOBIC (22.5 mg and greater) have been associated with an increased risk of serious GI events; therefore, the daily dose of MOBIC should not exceed 15 mg.

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Important NSAID risk information: Patients should be informed about the signs and/or symptoms of serious GI toxicity and the steps to take if they occur. It has been demonstrated that upper GI ulcers, gross bleeding or perforation, caused by NSAIDs, appear to occur in approximately 1% of the patients treated for 3-6 months, and in about 2-4% of patients treated for one year. Serious GI bleeding can occur without warning.

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References: 1. Yocum D, Fleischmann R, Dalgin P, et al. Safety and efficacy of meloxicam in the treatment of osteoarthritis: a 12-week, double-blind, multiple-dose, placebo-controlled trial. *Arch Intern Med.* 2000;160:2947-2954. 2. Singh G, Lanes S, Triadafilopoulos G. Risk of serious upper gastrointestinal and cardiovascular thromboembolic complications with meloxicam. *Am J Med.* 2004;117:100-106. 3. Data on file, Boehringer Ingelheim Pharmaceuticals, Inc.