Methods: We used the Scottish Care Information Diabetes (SCI Diabetes) database to identify patients in our hospital categorised as having pancreatogenic diabetes. Data on medications, screening for complications and demographic data were recorded. Hospital electronic records were used to obtain admission data.

Results: Eighty patients with pancreatogenic diabetes were identified (74% men, mean age 56.7 years). Seventy (87.5%) patients were on insulin; 8 (11%) on daily basal, 42 (60%) on mix and 20 (29%) on basal-bolus. Mean HbA1c was 66.1 mmol/mol. In the last 12 months, 49 (61%) had updated microalbumin screening, 40 (50%) updated retinal screening and 56 (70%) had recorded foot examination. Thirty-two (40%) were smokers and while 11 patients exceeded recommended alcohol intake, 54 (68%) patients had no recording of alcohol consumption. Thirty (38%) had an intake and microvascular disease screening. Thirty-two (40%) were smokers and while 11 patients exceeded recommended alcohol intake, 54 (68%) patients had no recording of alcohol consumption. Thirty (38%) had an admission to hospital relating to diabetes, 10 had impaired/absent hypoglycaemia awareness but 38 (47.5%) had no recording of hypoglycaemia awareness.

Conclusion: Since only those attending secondary care and recorded as having pancreatogenic diabetes were included, we believe this is an under-representation of our population with pancreatogenic diabetes. Nevertheless, we have identified a number of deficiencies in their management, with high rates of hospital admission, hypoglycaemia and suboptimal recording of alcohol intake and microvascular disease screening. By correctly identifying patients with pancreatogenic diabetes, we can create a better pathway for review and management of these patients.

P186
An audit evaluation of the effect of sodium glucose cotransporter inhibitors as an add-on to injectable therapy in Type 2 diabetes
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Aim: We sought to ascertain the real-world effectiveness of sodium glucose cotransporter-2 (SGLT-2) inhibitors as an add-on to injectable therapy (insulin/glucagon-like peptide (GLP)-1 agonists) in the routine care of patients with Type 2 diabetes in a hospital clinic setting.

Methods: Retrospective audit of data collected from patients initiated on SGLT-2 inhibitors as an add on therapy to injectable therapy. Data collection from clinical records on SCI-DC platform. Statistical analysis included paired analysis and repeated-measures analysis of variance.

Results: Three hundred and four patients in the clinic were initiated on SGLT-2 inhibitors (156 patients already receiving either insulin and GLP-1 agonists). Sixty-three were women, and 93 were men. Mean age was 56.9 ± 9.68 years. HbA1c value fell from a mean baseline value of 85.22 ± 15.72 mmol/mol to 73.39 ± 18.27 mmol/mol (p = 0.0001) after six months, to 74.49 ± 19.01 mmol/mol (p = 0.0001) at 12 months and 72.41 ± 18.63 mmol/mol (p = 0.0001) at 18 months. Systolic blood pressure fell from a baseline value (134.76 ± 16.18 (p = 0.0043), 135.64 ± 20.32 (p = 0.043)) vs 140.82 ± 19.20 mm Hg. There was a significant decline in body weight and body mass index observed at the end of 18th month from the baseline (34.8109 ± 5.677 (p = 0.05) vs 36.8449 ± 7.9684 kg/m2). The discontinuation rate due to intolerance to side effects was 1.9%.

Conclusion: SGLT-2 inhibitors are effective at improving glycaemic control as well as lowering systolic blood pressure and body weight in patients with Type 2 diabetes already receiving injectable therapy.

Clinical care and other categories posters: Cardiovascular

P187
Does baseline HbA1c or change in HbA1c predict the reduction in cardiovascular death with empagliflozin? Results from EMPA-REG OUTCOME
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Aims: Instituting strict glycaemic control of Type 2 diabetes may confer risk of subsequent myocardial infarction (MI), particularly if diabetes was longstanding. Using diabetic retinopathy (DR) as a surrogate measure for duration of subclinical Type 2 diabetes, we evaluated whether change in HbA1c, achieved 12 months after Type 2 diabetes diagnosis, confers risk of MI over five years in those with/without DR at diagnosis.

Methods: Analysis of the Royal College of General Practitioners Research & Surveillance Centre database. Clinical codes define the presence of comorbidities and diabetes complications. Patients with new diagnosis of Type 2 diabetes, between 2004 and 2011, were identified. MI within 12 months of Type 2 diabetes were
P189

Empagliflozin reduces mortality in analyses adjusted for control of blood pressure, low-density lipoprotein cholesterol and HbA1c over time

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Aims: In EMPA-REG OUTCOME, empagliflozin given in addition to standard of care significantly reduced the risk of cardiovascular (CV) (HR 0.62 [95% CI 0.49, 0.77]) and all-cause (0.68 [0.57, 0.82]) mortality vs placebo in patients with Type 2 diabetes and established CV disease. We investigated the effects of controlling blood pressure (BP), low-density lipoprotein cholesterol (LDL-C) and HbA1c on the treatment difference in mortality.

Methods: Patients were randomised to empagliflozin 10mg, empagliflozin 25mg, or placebo. CV and all-cause mortality were assessed in the pooled empagliflozin group vs placebo adjusting for control of BP, LDL-C and HbA1c at baseline and during the study as time-dependent covariates. Control was defined as systolic BP <140mm Hg and diastolic BP <90mm Hg, LDL-C <100mg/dl, and HbA1c <7.5%.

Results: Adjusting for control of BP, LDL-C, HbA1c and all these covariates at baseline and during the study, HRs (95% CI) for CV death with empagliflozin vs placebo were 0.61 (0.49, 0.76), 0.59 (0.47, 0.75), 0.62 (0.49, 0.78) and 0.61 (0.48, 0.76), and for all-cause mortality were 0.67 (0.56, 0.81), 0.66 (0.55, 0.79), 0.67 (0.56, 0.81) and 0.67 (0.56, 0.81), respectively.

Conclusions: Empagliflozin reduced CV and all-cause mortality to the same extent when analyses were adjusted for control of BP, LDL-C and HbA1c over time, suggesting that the mortality reductions were not driven by controlling or not controlling these CV risk factors during the study.

P190

EMPA-REG OUTCOME: Consistent reduction in risk of cardiovascular outcomes and mortality with empagliflozin irrespective of sulphonylurea use at baseline

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Aims: In the EMPA-REG OUTCOME trial, empagliflozin reduced cardiovascular (CV) death by 38% vs placebo in patients with Type 2 diabetes and established CV disease. We investigated CV outcomes and mortality by sulphonylurea use at baseline.

Methods: Patients were randomised to placebo, empagliflozin 10mg or empagliflozin 25mg in addition to standard of care. Background glucose-lowering therapy was to remain unchanged for 12 weeks and then be adjusted to achieve glycaemic control according to local guidelines. Outcomes with empagliflozin pooled vs placebo by baseline sulphonylurea use were assessed using a Cox proportional hazards model.

Results: In total, 2,333, 2,345 and 2,342 patients received placebo, empagliflozin 10mg and empagliflozin 25mg, of whom 42.5%, 42.0% and 43.9%, respectively, were taking sulphonylurea (alone or with other glucose-lowering medications) at baseline. Confirmed hypoglycaemic adverse events (plasma glucose ≤70mg/dl and/or requiring assistance) were reported in 23.4%, 24.5% and 25.0% of patients in placebo, empagliflozin 10mg and empagliflozin 25mg groups taking sulphonylurea, and 31.2%, 30.5% and 29.7% in these groups not taking sulphonylurea, respectively. HRs (95% CI) for CV death in patients taking and not taking sulphonylurea were 0.64 (0.44, 0.92) and 0.61 (0.46, 0.81), respectively (p = 0.85 for treatment-by-subgroup interaction); for all-cause mortality were 0.66 (0.49, 0.88), and 0.70 (0.55, 0.89), respectively (p = 0.73 for interaction); and for hospitalisation for heart failure were 0.65 (0.40, 1.04) and 0.66 (0.48, 0.91), respectively (p = 0.95 for interaction).

Conclusions: In the EMPA-REG OUTCOME trial, empagliflozin reduced CV outcomes and mortality irrespective of sulphonylurea use at baseline.

P191

Dapagliflozin vs empagliflozin: A one-year retrospective propensity score matched comparison of modifiable cardiovascular risk factors

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Aims: Cardiovascular events are the leading cause of death among people with Type 2 diabetes. SGLT-2 inhibitors have emerged as a promising drug class as they exhibit beneficial effects upon metabolic parameters associated with cardiovascular mortality. We aimed to investigate and compare the impact of dapagliflozin and empagliflozin upon modifiable cardiovascular risk factors.

Methods: Two hundred and sixty-nine individuals prescribed dapagliflozin or empagliflozin in Stobhill Hospital, Glasgow, UK, were identified. Propensity score matched groups were defined to compare within and between group differences in modifiable risk factors following one year of SGLT-2 inhibitor use. Ten-year risk
estimates for coronary heart disease (CHD), fatal CHD, stroke and fatal stroke were calculated and compared between groups using the UK Prospective Diabetes Study UKPDS risk engine.

**Results:** The dapagliflozin cohort (n = 50) demonstrated a reduction in HbA1c (−12.5mmol/mol, p < 0.001), systolic blood pressure (−6.6mm Hg, p = 0.04), weight (−4.5 kg, p < 0.001), and a rise in high-density lipoprotein cholesterol (0.07 mmol/l, p = 0.005). A decrease in HbA1c (−13.6mmol/mol, p < 0.001), systolic blood pressure (−6.4mm Hg, p = 0.02) and weight (−3.6kg, p < 0.001) were also observed in the empagliflozin cohort (n = 50). A reduction in UKPDS CHD and fatal CHD risk were evident in both groups (p < 0.01). Between group differences in SGLT-2 inhibitor subtypes were not observed (p > 0.05).

**Conclusion:** The effect of dapagliflozin and empagliflozin upon HbA1c, systolic blood pressure, weight and CHD risk were comparable and independent of SGLT-2 subtype. The DECLARE study may clarify whether the favourable cardiometabolic profile of dapagliflozin can be translated into cardiovascular outcomes, as demonstrated by empagliflozin in the EMPA-REG OUTCOME study.

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**Clinical care and other categories posters: Case reports**

**P192**

*Enhanced peptide immunotherapy: Case report of first-in-man delivery of proinsulin peptide attached to gold nanoparticles*

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Refer to Oral number A23

**P193**

*Type 1 diabetes ‘honeymoon’ is almost four times longer in people who exercise*

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Refer to Oral number A25

**P194**

*Type 2 diabetes and acquired reactive perforating collagenaosis*

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Refer to Oral number A26

**P195**

*Diabetic myonecrosis: A serious and under-recognised complication of long-standing diabetes*

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Refer to Oral number A27

**P196**

*Sustained glycaemic improvement with continuous subcutaneous insulin infusion (CSII) therapy in a patient with insulin-resistant Type 2 diabetes: A case report*

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Refer to Oral number A28

**P197**

*Painless foot drop: An unusual presentation of new-onset Type 1 diabetes*

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A 26-year-old Caucasian woman presented to the emergency department with new-onset painless left foot drop preceded by a four-day history of foot weakness and numbness. There was no history of compression or mechanical injury. Medical history and family history was unremarkable. Neurological examination revealed reduced power in dorsiflexion of left ankle with normal sensation and reflexes. No other abnormalities were identified. General examination was unremarkable. Results from a panel of blood tests were normal except an elevated blood glucose of 49.9mmol/l which prompted referral to the diabetes team. Investigations excluded HIV-associated mononeuropathy, vasculitic, toxic, nutritional/metabolic and other endocrine causes. Diabetes auto-antibodies were elevated. The patient was admitted and insulin regimen initiated. Nerve conduction studies demonstrated a left common peroneal nerve lesion with conduction block at the fibular head. There was a significant improvement of her foot drop after 1 week of insulin treatment.

Nearby 96% of adults with new onset Type 1 diabetes present with classic symptoms such as polyuria, polydipsia, fatigue and weight loss. Mononeuropathy in diabetes may have a sudden onset and most often involves the median (5.8%), ulnar (2.1%) and less frequently the common peroneal nerves (0.1%). Risk factors include older age and longer duration of diabetes. As far as we are aware, there are no similar cases of foot drop as a presenting feature of Type 1 diabetes in the published literature. Our case

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