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Heterogeneous treatment effects on cardiovascular diseases with dipeptidyl peptidase-4 inhibitors versus sulfonylureas in type 2 diabetes patients

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Abstract

This study explored heterogeneous treatment effects (HTEs) of the real-world use of dipeptidyl peptidase-4 inhibitors (DPP-4i) versus sulfonylureas (SU) on cardiovascular diseases (CVDs) and mortality in type 2 diabetes.

Utilizing Taiwan's National Health Insurance Research Database, 19,853 propensity score-matched pairs of DPP-4i and SU stable users were identified. Classification and regression tree analyses and Cox models were applied to explore HTEs, according to various patient characteristics, on the composite CVDs, three-point major adverse cardiovascular event (MACE), and all-cause mortality. The absolute risk difference (ARD), hazard ratio (HR) and 95% confidence interval (CI) were estimated for comparing treatment effects.

CVD history, ischemic stroke or transient ischemic attack (IS/TIA) history, and age at treatment initiation were significant treatment effect modifiers. Patients with prior IS/TIA but without any other prior CVDs benefited most in reduced risks of composite CVDs from using DPP-4i vs. SU (ARD: -4.31% [95% CI: -7.48%, -1.14%], HR: 0.81 [95% CI: 0.69~0.95]), followed by those without prior IS/TIA and CVDs and initiated with DPP-4i at age <69.3 years (ARD: -0.90% [-1.47%, -0.32%], HR: 0.86 [0.77~0.97]). Patients with prior IS/TIA benefited most in reduced risks of three-point MACE from using DPP-4i vs. SU (ARD: -4.22% [-6.66%, -1.78%], HR: 0.80 [0.69~0.93]), followed by those without prior IS/TIA and initiated with DPP-4i at age <69.3 years (ARD: -0.68% [-1.08%, -0.29%], HR: 0.81 [0.70~0.93]).

Consideration of CVD and IS/TIA histories and age could facilitate individualized diabetes management of using DPP-4i versus SU. Future studies are warranted given the hypothesis-generating nature in this exploratory research.

Introduction

Dipeptidyl peptidase-4 inhibitors (DPP-4i) are commonly used as a second- or third-line glucose-lowering agent (GLA) (1). They have shown moderate glucose-lowering efficacy with a low risk of hypoglycemia, a neutral effect on body weight, and lower drug acquisition costs compared to other newer drugs such as glucagon-like peptide-1 (GLP-1) receptor agonists and sodium-glucose cotransporter 2 (SGLT2) inhibitors (2). All of four large cardiovascular outcome trials for DPP-4i used a placebo-controlled design and did not show cardiovascular benefits relative to placebo (3-6). The CAROLINA (7) was the only large, randomized, active comparator trial of DPP-4i (linagliptin) versus sulfonylureas (SU; glimepiride), another commonly used GLA, and it revealed that the use of DPP-4i relative to SU did not yield beneficial cardiovascular effects either. Nevertheless, our literature review (Table S1) has found that numerous cohort studies (8-17) for assessing long-term comparative risks of cardiovascular diseases (CVDs) associated with the real-world use of DPP-4i versus SU showed the significantly reduced risks of CVDs from DPP-4i versus SU.

These inconsistent results of CVD outcomes associated with the use of DPP-4i between clinical trials and real-world studies have implied the importance of evaluating potential heterogeneous treatment effects (HTEs) of DPP-4i, which could be hidden in a diverse real-world patient population with type 2 diabetes (T2D). That is, treatment outcomes may differ across patient subgroups by demographic and clinical characteristics. The results of investigating HTEs would be critical in clinical care for determining personalized treatments and in healthcare policy decisions for formulating effective healthcare reimbursement policies, which can be used to prioritize treatment strategies to gain benefit and avoid harm for patients.

Against this background, this study explored the complexity of multiple clinical factors that could explain heterogeneous cardiovascular effects of DPP-4i versus SU in real-world T2D patients by using machine learning approaches that have been increasingly applied to analyze HTEs of antidiabetic treatments (18, 19).

Methods

The Institutional Review Board of National Cheng Kung University Hospital approved the study before commencement (B-EX-103-015).

Data source

This study utilized data from the National Health Insurance Research Database (NHIRD) recorded from 1996 to 2013, which comprised de-identified, individual-level, longitudinal claims data of medical and pharmacy records from Taiwan's National Health Insurance (NHI) program (20). The NHI program is a mandatory-enrollment single-payment system that covers over 99% of the population of 23 million people in Taiwan (21).

Cohort identification

The prevalence of T2D in people aged 20-79 years in Taiwan during 2000-2013 was from 4.3% to 9.8% (22, 23). In this study, patients aged 18 years or above and newly diagnosed with T2D were identified from the NHIRD 1999-2013 and those receiving DPP-4i or SU during 2011-2012 were further identified (Figure S1). Patients using the combination of DPP-4i and SU were excluded because the main interest of study was to assess the individual effect and HTEs of DPP-4i versus SU. The period of 2011-2012 was chosen because the reimbursement of DPP-4i by the NHI program started since 2009 and the utilization of DPP-4i increased steadily after 2010 in Taiwan (1). During 2011-2013, SU and

DPP-4i were among the most frequently used 2nd-line GLAs for the T2D patients failing to metformin monotherapy (1). We then identified stable users of study drugs who newly initiated DPP-4i (n=66,400) or SU (n=21,600) in 2011-2012 without any prescriptions of these drugs in the preceding year. To avoid potential confounding from short-term or accidental use of study drugs, we selected stable users of DPP-4i or SU; stable users were patients with at least three consecutive refills of DPP-4i or SU with any gaps between two consecutive refills of less than 30 days (11, 24). The index date for each study subject was the first date of initiating DPP-4i or SU during 2011-2012.

The propensity score (PS) matching procedure of the 8-digit greedy, nearest-neighbor 1:1 matching was applied to minimize the potential selection bias and enhance the comparability of two treatment groups. The critical baseline patient characteristics shown in Table 1 were considered in the PS matching procedure, and the standardized mean difference (SMD) statistics was used to indicate a satisfactory balance in patient characteristics between treatment groups if an absolute SMD value was less than 0.1.

Operational definitions of medications and outcomes

In the NHIRD, the exposure of GLAs and CVD-related medications (Table 1) was measured according to the World Health Organization Anatomical Therapeutic Chemical Classification system. Study outcomes included: 1) the composite CVD event consisting of fatal or non-fatal myocardial infarction, ischemic heart disease, heart failure, cerebrovascular disease, cardiogenic shock, sudden cardiac arrest, arteriosclerotic cardiovascular disease, or arrhythmia, 2) three-point major adverse cardiovascular event (MACE) including non-fatal myocardial infarction or stroke, or fatal CVDs, and 3) all-cause mortality. Cardiovascular events were confirmed using ICD-9-CM codes from inpatient or emergency department

records of the NHIRD, and the mortality status was ascertained from inpatient department records (Table S2). The coding accuracy for study outcomes in the NHIRD has been documented elsewhere (11, 25-28).

Statistical analyses

Our main analyses were conducted for patients without prior severe hypoglycemia (primary cohort) under an intention-to-treat (ITT) scenario. The ITT scenario analyses considered each subject to be observed from the index date until loss to follow-up from the NHI program, occurrence of a study outcome, or the end date of the database (12/31/2013), whichever came first. Classification and regression tree (CART) analysis was applied to classify heterogeneous patient subgroups stratified by underlying demographic and clinical characteristics who had substantially different treatment effects. The CART is a commonly-used and powerful machine-learning method in which the data are split into several subgroups, namely a node or leaf, by input predictors (e.g., demographic or clinical characteristics) indicating the heterogeneous features between the subgroups. The CART utilizes the common impurity approaches (e.g., Gini index for a binary outcome variable or minimizing the sum squared error for a continuous outcome variable) to assess the appropriateness of the classification for subgroups with the most homogeneous value of a given outcome (29, 30). The CART is a predictive algorithm for classifying patient subgroups by partitioning the data and fitting a prediction model within each subgroup (29, 31). The CART is a well-developed technique for analyzing the right-censored survival data, especially incorporating time-dependent covariates into tree structure analyses. All patient characteristics (Table 1) were employed in the CART analysis as the potential estimators/factors that partitioned the data by differentiating the hazards of study outcomes

associated with the treatment status (DPP-4i versus SU). The final sets of subgroups (as nodes at the bottom of the tree) determined/split by all significant factors selected in CART yielded maximum between-group differences and minimum within-group differences in treatment effects for a given study outcome. Furthermore, five-fold cross-validation was performed to ensure the validity of the estimators' performance.

For the most representative subgroups defined from the CART analysis, we further performed the Cox proportional hazard models to assess the hazards of study outcomes associated with treatment status in each subgroup. Results were presented as hazard ratios (HRs) and 95% confidence intervals (CIs). The stratified log-rank test was then performed to test the trend in the hazards of study outcomes across subgroups/nodes. Additionally, the absolute risk difference (ARD) in the event rates of study outcomes between treatments in each subgroup (node) was estimated. In contrast to conventional relative measures (e.g., HRs), ARD results provide a clinically meaningful absolute estimate (32), and thus ARD is commonly used in studies of HTEs for assessing the performance of a decision tree analysis (18, 19). The c-statistic, which is equal to the area under the receiver operating characteristic curve, was reported to demonstrate the goodness of fit of the Cox models performed in each subgroup/node (33). The significance of the goodness of fit for each Cox model was further assessed using the likelihood ratio test.

Additionally, to account for possible over-estimation of treatment effects in the ITT scenario analyses, where non-adherence to medications was ignored, we performed analyses based on an as-treated (AT) scenario where patients who switched from or discontinued the study drug were also censored in addition to those censored points used in the ITT scenario analyses. Moreover, considering the potential link between hypoglycemia and CVD risks

(34), we constructed a secondary cohort where prior severe hypoglycemia (i.e., hospitalized hypoglycemia in the year prior to the index date) was adjusted in the analysis. Specifically, severe hypoglycemia was included as one of the variables for PS estimation in the beginning of deriving the study cohort and treated as a potential estimator/factor for splitting the data to determine the subgroups/nodes in the CART analysis. Tree analyses using the secondary cohort were performed under ITT and AT scenarios. A two-tail *p*-value of < 0.05 was considered statistically significant. All analyses were conducted using R software version 3.6.1.

Results

Table S3 presents the patient characteristics before the PS matching. Through the PS matching procedure, 19,853 and 19,856 PS-matched pairs of DPP-4i and SU stable users were included in the primary and secondary cohorts, respectively (Table 1). All patient characteristics were comparable between the treatment groups after the PS matching.

The overall analysis results based on the primary cohort under ITT scenario indicated that the use of DPP-4i versus SU significantly reduced the risks of composite CVD and three-point MACE by 8% (HR 0.92, 95% CI 0.87-0.97) and 18% (0.82, 0.75-0.89), respectively, but had no significant effect for all-cause death (0.94, 0.80-1.10). Figure 1(a) shows CVD history, ischemic stroke or transient ischemic attack (TIA) history, and age at the index date, which split the study subjects into four subgroups/nodes with significantly different risks of composite CVD associated with DPP-4i versus SU use, as reported in Table 2. Although the log-rank test results for the ARD in composite CVD between treatments are only statistically significant in subgroups 1 and 3 ($p < 0.05$), the stratified log-rank test for the difference in the

hazards of composite CVD for DPP-4i versus SU use across four subgroups is statistically significant (p = 0.002), which supports significant HTEs across these subgroups. Subgroup 1 (without CVD history, ischemic stroke or TIA history, and age at the index date of less than 69.3 years) comprised 56.5% of the sample and had a significant reduction in ARD for composite CVD with DPP-4i versus SU use of 0.90% (95% CI 0.32%-1.47% decrease, HR 0.86, 95% CI 0.77-0.97). Subgroup 3 (without CVD history but with ischemic stroke or TIA history) accounted for 6.7% of the study subjects and had a significant reduction in ARD for composite CVD with DPP-4i versus SU use of 4.31% (95% CI 1.14%-7.48% decrease, HR 0.81, 95% CI 0.69-0.95). The results of the c-statistic across the models in the four subgroups ranged from 0.646 (subgroup 3) to 0.719 (subgroup 1).

Figure 1(b) shows age at the index date, prior diuretic use, and CVD history, splitting the study subjects into five subgroups that had different mortality outcomes associated with DPP-4i versus SU use. However, the heterogeneity of all-cause mortality with DPP-4i versus SU use across these subgroups was not supported; the stratified log-rank test for the trend in the hazards of all-cause mortality across subgroups is not significant (p = 0.442) (Table 2).

Figure 1(c) shows ischemic stroke or TIA history and age at the index date, partitioning the study patients into three subgroups for different risks of three-point MACE between DPP-4i and SU use, as reported in Table 2. All log-rank tests for the ARD in three-point MACE between DPP-4i and SU use in individual subgroups and the stratified log-rank test for the difference in the hazards of three-point MACE across subgroups are statistically significant. Subgroups 1 (without ischemic stroke or TIA history, and age at the index date of < 69.3 years), 2 (without ischemic stroke or TIA history and age at the index date of ≥ 69.3 years), and 3 (with ischemic stroke or TIA history) accounted for 69.5%, 20.7%, and 9.8% of the

study subjects, respectively, and had significant reductions in the ARD for three-point MACE with DPP-4i versus SU use of 0.68% (95% CI 0.29%-1.08% decrease, HR 0.81, 95% CI 0.70-0.93), 1.72% (95% CI 0.49%-2.95% decrease, HR 0.85, 95% CI 0.73-0.98), and 4.22% (95% CI 1.78%-6.66% decrease, HR 0.80, 95% CI 0.69-0.93), respectively. Among these subgroups, the c-statistic in the models ranged from 0.647 (subgroup 3) to 0.736 (subgroup 1).

Figure S2 shows the results of the analyses of the primary cohort under the AT scenario. The findings are generally consistent with those from the analyses under the ITT scenario (Figure 1), except for the all-cause death outcome; in the AT scenario, the tree analysis only partitioned the patients into three subgroups according to two variables, namely age at the index date and prior diuretic use (Figure S2(b)). Consistent with the results in Table 2, Table S4 shows significant heterogeneity of composite CVD and three-point MACE between DPP-4i and SU use across the subgroups, as supported by statistically significant results of the stratified log-rank test for the trend in the hazards across subgroups ($p = 0.001$ and $p < 0.001$, respectively); the heterogeneity of all-cause mortality between treatments across the subgroups was not significant.

Figures S3 and S4 show the results of the tree analyses for the secondary cohort (with consideration of severe hypoglycemia) under the ITT and AT scenarios, respectively. These results are consistent with the findings using the primary cohort for all three study outcomes regarding the factors/characteristics identified for subgroups, although the cut-off point for age at the index date for splitting the sample is slightly different between the analyses using the two different cohorts. Tables S5 and S6 show the detailed results of ARD and HRs for study outcomes between treatments, statistical testing for the ARD in individual subgroups,

and the trend in the HRs across subgroups based on the secondary cohort, which are consistent with the findings from the analyses of the primary cohort (Table 2 and Table S4), except the all-cause mortality outcome.

Discussion

Existing studies commonly only report the average treatment effects between treatment groups. This study is the first of its kind to suggest significant HTEs on cardiovascular outcomes associated with the use of DPP-4i versus SU across certain subgroups of patients with T2D. These heterogeneities may facilitate explanations of current inconsistent study results of comparative cardiovascular effects of DPP-4i versus SU. We found that the relative risk of composite CVD for using DPP-4i versus SU varied significantly in the four sets of patient subgroups stratified by a combination of three factors/characteristics: CVD history, ischemic stroke or TIA history, and age at the date of initiating DPP-4i or SU. Among these subgroups, the patients with ischemic stroke or TIA history but without any other established CVDs (subgroup 3) had the most risk reduction in the composite CVD by using DPP-4i instead of SU, followed by those without CVD, ischemic stroke, or TIA history and initiated with DPP-4i at the age of < 69.3 years (subgroup 1). In addition, the relative risk of three-point MACE with using DPP-4i versus SU varied in the three patient subgroups stratified by a combination of ischemic stroke or TIA history and age at the date of initiating DPP-4i or SU; those with ischemic stroke or TIA history (subgroup 3) had the most benefit of the reduced three-point MACE from using DPP-4i instead of SU, followed by those without ischemic stroke or TIA history and with an age at the time of the initiating DPP-4i of < 69.3 years (subgroup 1) and those without ischemic stroke or TIA history and with an age at the

time of initiating DPP-4i of ≥ 69.3 years (subgroup 2). Moreover, although a possible link between hypoglycemia and CVD risks has been documented (34), our separate analyses using primary and secondary cohorts yielded consistent results and the history of severe hypoglycemia was not selected as a significant factor in CART analyses using the secondary cohort, suggesting that relative to prior severe hypoglycemia, the CVD history, ischemic stroke or TIA history, and age of initiating drugs may play a more important role in explaining the comparative CVD risks of using DPP-4i versus SU. Because we considered severe hypoglycemia before treatment initiation, one could argue that prior severe hypoglycemia episodes might have a limited impact on the future development of CVDs.

Although no comparable studies have assessed the HTEs of DPP-4i versus SU on CVD risks, numerous studies have used the conventional univariable analysis to characterize subgroups that may vary in treatment effects. However, most studies analyzed treatment effects only in a single subgroup of patients with established CVD events but did not assess other subgroups such as patients without CVD history (8, 9, 11, 12, 15, 16, 35, 36). Such analyses cannot answer whether there is an interaction between the status of CVD history (yes versus no) and treatment status (DPP-4i versus SU). Furthermore, in the patient subgroup with established CVD events, the results of comparative CVD risks for DPP-4i versus SU are inconsistent; some studies showed that the use of DPP-4i versus SU yielded a significantly lower CVD risk (9, 11, 12, 17, 36), whereas others demonstrated no difference between DPP-4i and SU (8, 35). Demographic variables such age at treatment initiation (37, 38) and gender (13, 37-39) were also considered in the previous univariable analyses. However, the results of these demographic subgroups were inconsistent (13, 37-39) and the cut-off point for the stratification of age subgroups varied among studies (37, 38).

Considering that heterogeneous patient subgroups that vary in treatment responses in real-world clinical practice cannot be easily characterized by a single demographic or clinical factor/characteristic, the complexity of the relationships between multiple factors and treatment outcomes is unlikely to be revealed by conventional univariable subgroup analyses. Real-world patient subgroups are likely to have mixed factors, the interactions of which could influence treatment responses. Hence, it has been argued that conventional univariable analyses lack the statistical power to detect heterogeneity of treatment effects among subgroup patients (18, 19). Univariable analysis results should be cautiously applied because of potential false-positive biases due to multiple testing errors (e.g., overfitting due to multiple comparisons) (32, 40, 41).

Compared to previous studies on cardiovascular safety of DPP-4i versus SU, the present study has several methodological strengths. First, in contrast to previous univariable analyses, we employed advanced machine learning approaches to consider multiple simultaneous covariates and the interactions among them, which would thus provide better estimations and explanations for variations in the treatment effects. Second, although some factors associated with the HTEs of DPP-4i versus SU identified in this study (i.e., CVD history, age) are consistent with the findings from previous univariable analyses, the assessment of patient subsets stratified by the combination of multiple factors in this study not only detected the significant treatment effects within each patient subset but also examined the significant HTEs across different patient subsets. Third, for a continuous variable (e.g., age), the data-driven machine learning approach determined the cut-off point based on the best data fit for study subjects, which avoided arbitrary assumptions or assignments on study variables. Fourth, the machine learning analysis in this study avoided the overfitting issue commonly

seen in traditional univariable analyses, which led to unbiased prediction for the differences in treatment effects between treatment groups. From a clinical perspective, there are several strengths and implications of this study. First, compared to the results of conventional univariable subgroup analyses, our findings based on data-driven multivariable subgroup analyses are more clinically relevant to real-world patient populations, which are commonly classified by multiple factors at the same time, and thus can assist clinician-patient discussions about selecting GLAs. Second, using rigorous machine learning analytic methods with cross-validation procedures, it is possible to identify subgroups of patients for which there is a substantial difference in treatment effects (i.e., beneficial or detrimental). Third, considering that multiple factors in combination may be required to explain clinically important variations in benefit or harm seen in real-world settings, the treatment responses (i.e., ARD estimates presented in this study) of patient subgroups are more readily interpretable by clinicians and patients and can thus facilitate personalized treatment decisions. Lastly, the visualized results of a decision tree analysis can be used to prioritize a series of important clinical factors/characteristics to facilitate personalized treatment decisions.

This study has several potential limitations. First, the causal inferences from study results should be cautiously applied and further verified in future studies because of the hypothesis-generating nature in this exploratory research. Particularly, future prospective studies are needed to determine complex physiological relationships among the selected variables for the stratification of patient subsets, which have not proven for causality in our variable selection procedures. Second, residual confounding by unmeasured factors (e.g., prescribers' preferences or behaviors, patients' preferences or their lifestyle behaviors,

laboratory data) may not be ruled out in this claims-based study. However, efforts to minimize unmeasured confounding have been made through the matching procedure that achieved a greater level of between-group comparability on various baseline patient characteristics. Third, because the two subgroups we tested were defined by the same covariates, the two tests for heterogeneity might not be independent (19). Fourth, from the perspective of clinical decisions, we only analyzed the baseline patient characteristics before or at treatment initiation as the potential factors of HTEs, rather than considered them as time-varying variables over time. Time-varying changes or variables measured after treatment initiation and before study outcome occurrence may also be associated with treatment outcomes. Fifth, the PS matching procedure enhanced the internal validity of the study, but the external validity may be concerned because a certain of proportion of patients was excluded after the matching process and all study subjects were Taiwanese patients. Hence, future research utilizing external databases comprised of other ethnic populations is warranted to assess the external validity of our findings. Lastly, the small number of death events may limit the power of this study to identify significant heterogeneous subgroups for this outcome.

In summary, this exploratory study suggests significant HTEs of using DPP-4i versus SU on cardiovascular outcomes in patients with T2D. The factors attributable to possible HTEs include the CVD history, ischemic stroke or TIA history, and age at drug initiation. Our analyses suggest that the use of DPP-4i instead of SU might be prioritized for patients with prior ischemic stroke or TIA and for those aged 69 years or lower without prior CVDs, and ischemic stroke or TIA. More broadly, this study highlights the importance of exploring clinically meaningful relationships among treatment interventions, clinical outcomes, and

patient characteristics to enhance personalized healthcare and efficient healthcare resource allocation to patients in need. Future research is encouraged to apply our analytical framework to explore potential HTEs of newer classes of antidiabetic drugs (i.e., GLP-1 receptor agonists, SGLT2 inhibitors) to guide individualized antidiabetic treatment and improve the quality of diabetes care.

Study Highlights

What is the current knowledge on the topic?

A large, randomized, active comparator trial revealed that the use of dipeptidyl peptidase-4 inhibitor (DPP-4i) in type 2 diabetes patients was noninferior to sulfonylurea (SU) for the composite cardiovascular disease (CVD) outcome, while several real-world comparative effectiveness studies showed the significantly reduced CVD risks from DPP-4i versus SU.

What question did this study address?

Potential heterogeneous treatment effects (HTEs) suggested by inconsistent results of CVD risks with DPP-4i versus SU were explored using machine learning-based analyses.

What does this study add to our knowledge?

CVD history, ischemic stroke or transient ischemic attack (IS/TIA) history and age were important factors contributing to heterogeneous CVD effects of DPP-4i versus SU. Patients with IS/TIA but without other CVD histories had up to a 20% CVD risk reduction by using DPP-4i, and those without IS/TIA and CVD histories and initiated with DPP-4i at age ≤69 years had up to a 19% CVD risk reduction.

How might this change clinical pharmacology or translational science?

The findings of HTEs for DPP-4i versus SU can facilitate individualized diabetes management.

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Author Contributions:

C.Y.Y., H.T.O. and S.K. wrote the manuscript; C.Y.Y., H.T.O. and S.K. designed the research; C.Y.Y., H.T.O., W.A.L., P.F.S., L.J.L. and C.T.Y. performed the research; C.Y.Y., W.A.L. and P.F.S. analyzed the data; W.A.L. and P.F.S. contributed new reagents/analytical tools.

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Figure legends

Figure 1: Subgroups classified by the tree analysis (analysis of primary cohort under intention-to-treat scenario)

Figure legend: (a) Composite cardiovascular disease event as the outcome, (b) all-cause death as the outcome, and (c) three-point major adverse cardiovascular event as the outcome. Each node/subgroup specifies the percentage of subjects partitioned by the significant factors identified by the tree analysis. For example, in Figure 1 (a), Subgroup 1 included 56.6% of patients in the primary cohort who did not have CVD, ischemic stroke, or transient ischemic attack (TIA) history and were aged below 69.3 years when initiating treatments. The absolute risk difference (ARD) with its 95% CI indicates the difference in the event rate of composite cardiovascular disease (CVD) between treatments. For example, Subgroup 1 had a significant reduction in the ARD for composite CVD with DPP-4i versus SU use of 0.90% (95% CI 0.32% to 1.47% decrease).

Abbreviations: CVD, cardiovascular; TIA, transient ischemic attack; ARD, absolutely risk reduction.

Supplementary Information

Supplemental Material

Supplemental Material Figure

Table 1: Baseline patient characteristics of DPP-4i and SU users after propensity score matching

Characteristics[*,†]	**Primary cohort (without adjustment for prior severe hypoglycemia)**[‡]		**Secondary cohort (with adjustment for prior severe hypoglycemia)**[‡]	
	DPP-4i (n=19,853)	**1:1 matched SU (n=19,853)**	**DPP-4i (n=19,856)**	**1:1 matched SU (n=19,856)**
Age at index date (year, mean ± SD)	60.65±12.39	60.38±12.78	60.73±12.44	60.35±12.77
Male (%)	53.30	54.34	54.04	54.38
Diabetes duration[§] (year, mean ± SD)	5.81±3.9	5.69±3.74	5.83±3.91	5.69±3.73
Glucose-lowering agent in the year before the index date (MPR, 0-1) (mean ± SD)				
Metformin	0.33±0.41	0.31±0.40	0.33±0.41	0.31±0.40
Meglitinide	0.10±0.28	0.11±0.28	0.10±0.28	0.11±0.28
Thiazolidinedione	0.09±0.25	0.10±0.27	0.09±0.25	0.10±0.27
Acarbose	0.10±0.27	0.11±0.28	0.10±0.27	0.11±0.28
Insulin	0.04±0.19	0.05±0.20	0.05±0.19	0.05±0.20
Diabetes-related complication (%)				
Retinopathy	10.05	10.15	10.20	10.15
Nephropathy	16.63	16.43	16.83	16.55
Neuropathy	11.80	11.47	12.02	11.51
Peripheral vascular diseases	5.19	5.21	5.27	5.27
Ischemic stroke or TIA[‖]	10.30	9.33	9.90	9.30
Other cerebrovascular diseases[‖]	6.81	6.47	6.85	6.39
Cardiovascular diseases[‖]	24.45	23.34	24.66	23.48
Metabolic complications	1.46	1.54	1.63	1.53

Hypertension	66.28	64.80	66.34	64.77
Hyperlipidemia	57.16	55.26	56.77	55.18
Severe hypoglycemia¶	N/A	N/A	1.71	1.59
CIC category (%)				
Cancer	6.97	6.88	7.16	6.89
Gastrointestinal disease	27.40	26.60	26.80	26.75
Musculoskeletal disease	38.95	38.43	39.13	38.63
Pulmonary disease	10.39	10.00	10.11	9.84
Substance abuse complexity	1.55	1.69	1.68	1.67
Mental illness	10.76	10.52	11.03	10.53
CVD-related medication (%)				
Lipid modifying agents	56.82	54.30	56.97	54.34
α-blockers	5.17	4.92	5.07	4.89
β-blockers	34.52	33.81	34.59	33.86
Agents acting on the renin-angiotensin system	56.85	54.74	56.82	54.83
Diuretics	19.68	19.70	20.11	19.79
CCBs	40.87	40.70	41.11	40.69
Antiarrhythmics	2.45	2.20	2.34	2.23
Cardiac glycosides	2.52	2.36	2.43	2.38
Vasodilators used in cardiac diseases	13.65	12.68	13.60	12.86
Anti-platelets	38.56	36.89	37.96	37.04
Anti-coagulants	1.62	1.47	1.59	1.48

Abbreviations: DPP-4i, dipeptidyl peptidase-4 inhibitor; SU, sulfonylurea; SD, standard deviation; MPR, medication possession ratio; TIA, transient ischemic attack; CIC, chronic illness with complexity; CCBs,

calcium channel blockers. N/A: not available; the history of severe hypoglycemia was not measured in the primary cohort.

Notes:

* All patient characteristics after propensity score matching were comparable between the two treatment groups, as supported by the value of the absolute standardized mean difference (SMD) of less than 0.1.

† All patient characteristics were measured in the year prior to the index date (i.e., the first date of initiation of DPP-4i or SU during 2011-2012), except age and gender, which were measured at the index date; all characteristics were included in the estimation of propensity scores and treated as estimators/factors in the decision tree analysis.

‡ Severe hypoglycemia was only measured and included for propensity score estimation and the decision tree analysis in the secondary cohort.

§Diabetes duration was measured as the time from the first date of type 2 diabetes diagnosis to the index date.

|| Ischemic stroke or TIA, other cerebrovascular diseases, and cardiovascular diseases at baseline were measured mutually exclusively.

¶ Severe hypoglycemia was defined as hospital admission or emergency department records for hypoglycemia.

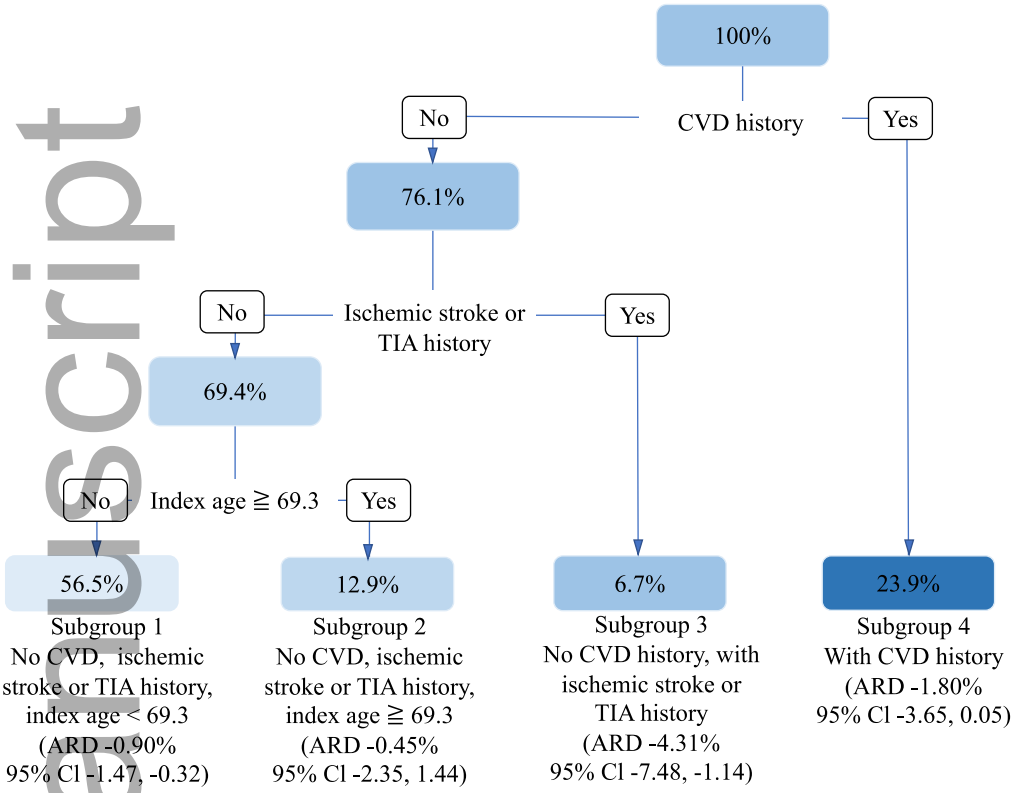
Table 2: Study outcomes associated with DPP-4i versus SU use stratified by subgroups identified by the tree analysis (analysis of primary cohort under intention-to-treat scenario)

No. of DPP-4i users (No. of events)	No. of SU users (No. of events)	Absolute risk difference (ARD) in event rate between treatments, % (95% CI)	p-value of log-rank test for ARD	Hazard ratio (HR) (95% CI)	c-statistic (95% CI)	p-value of stratified log-rank test for difference in HRs across subgroups
Outcome: Composite cardiovascular disease event						
Subgroup 1: No CVD, ischemic stroke, or TIA history, index age < 69.3						
11,311 (529)	11,123 (620)	-0.90 (-1.47, -0.32)	0.036	0.86 (0.77, 0.97)	0.719 (0.702, 0.737)	0.002
Subgroup 2: No CVD, ischemic stroke, or TIA history, index age ≥ 69.3						
2,597 (353)	2,506 (352)	-0.45 (-2.35, 1.44)	0.846	0.96 (0.83, 1.12)	0.663 (0.641, 0.685)	
Subgroup 3: No CVD history, with ischemic stroke or TIA history						
1,311 (271)	1,369 (342)	-4.31 (-7.48, -1.14)	0.027	0.81 (0.69, 0.95)	0.646 (0.623, 0.670)	
Subgroup 4: With CVD history						
4,634 (1,354)	4,855 (1,506)	-1.80 (-3.65, 0.05)	0.324	0.99 (0.92, 1.06)	0.674 (0.663, 0.685)	
Outcome: All-cause death						
Subgroup 1: Index age < 62.6 years, no prior diuretic use						
10,127 (35)	10,001 (38)	-0.03 (-0.20, 0.13)	0.981	1.07 (0.67, 1.69)	0.829 (0.760, 0.899)	0.442

Subgroup 2: Index age ≥ 62.6 and < 72.7 years, no prior diuretic use						
3,453 (37)	3,621 (53)	-0.39 (-0.91, 0.13)	0.252	0.81 (0.53, 1.24)	0.811 (0.749, 0.874)	
Subgroup 3: Index age < 72.7 years, with prior diuretic use						
2,675 (59)	2,658 (54)	0.17 (-0.60, 0.95)	0.410	1.08 (0.74, 1.56)	0.791 (0.735, 0.846)	
Subgroup 4: Index age ≥ 72.7 years, no CVD history						
2,186 (67)	2,095 (68)	-0.18 (-1.23, 0.87)	0.865	0.97 (0.69, 1.36)	0.749 (0.698, 0.800)	
Subgroup 5: Index age ≥ 72.7 years, with CVD history						
1,412 (97)	1,478 (124)	-1.52 (-3.45, 0.41)	0.302	0.86 (0.66, 1.13)	0.722 (0.682, 0.761)	
Outcome: 3-point major adverse cardiovascular event						
Subgroup 1: No ischemic stroke or TIA history, index age < 69.3 years						
13,859 (356)	13,721 (446)	-0.68 (-1.08, -0.29)	0.010	0.81 (0.70, 0.93)	0.736 (0.715, 0.756)	< 0.001
Subgroup 2: No ischemic stroke or TIA history, index age ≥ 69.3 years						
4,142 (333)	4,088 (399)	-1.72 (-2.95, -0.49)	0.036	0.85 (0.73, 0.98)	0.667 (0.646, 0.689)	
Subgroup 3: With ischemic or TIA history						
1,852 (306)	2,044 (424)	-4.22 (-6.66, -1.78)	0.004	0.80 (0.69, 0.93)	0.647 (0.625, 0.668)	

Abbreviations: DPP-4i, dipeptidyl peptidase-4 inhibitor; SU, sulfonylurea; CVD, cardiovascular disease; TIA, transient ischemic attack.

(a)



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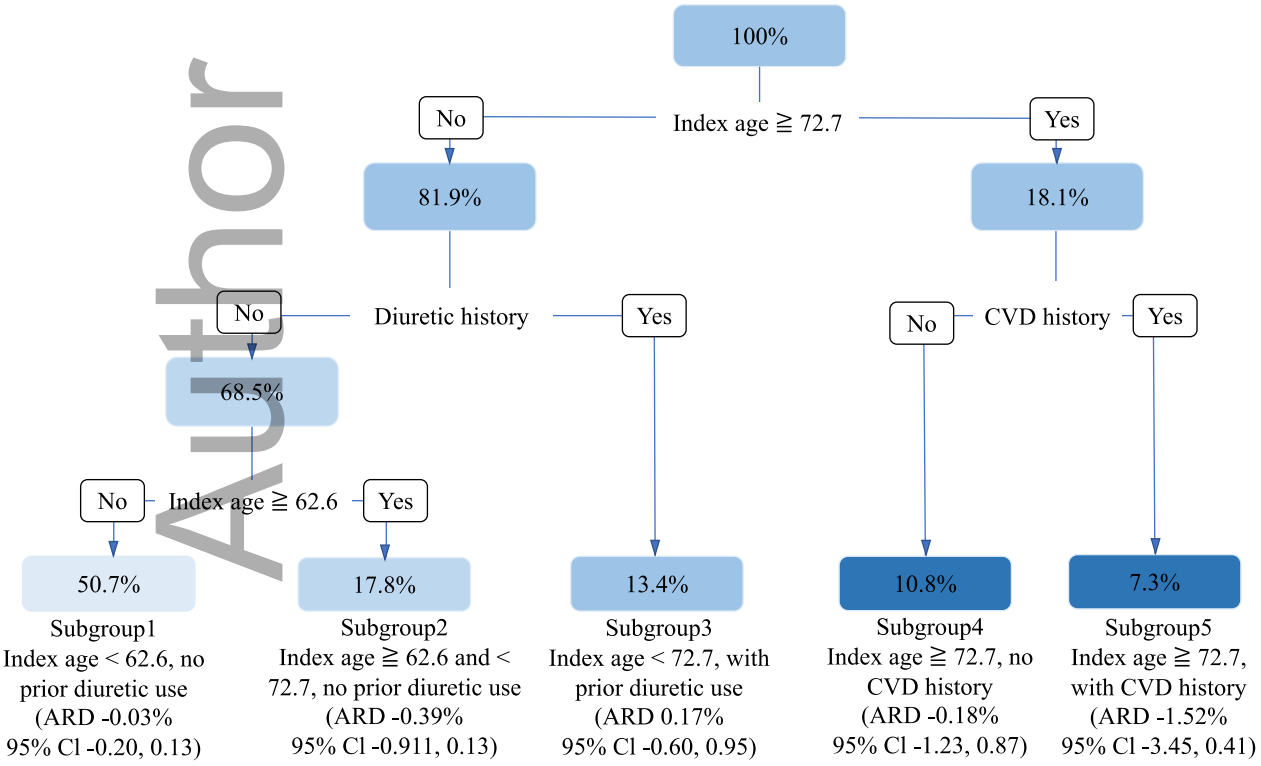

(c)