2237. Validity of Self-Reported HCV Status Among Justice-Involved Persons Living with HIV

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Session: 239. HIV and Viral Hepatitis Co-Infection
Saturday, October 6, 2018: 12:30 PM
Background. The prevalence of hepatitis C virus (HCV) and human immunodeficiency virus (HIV)-1 co-infection among justice-involved persons is high and HCV health literacy is low. The validity of self-reported HCV status in this population has important implications for HCV testing and education programs inside correctional facilities and in the community after release, yet its assessment is limited.

Methods. HIV-positive justice-involved persons from the District of Columbia were enrolled into a study evaluating a health intervention for improved HIV treatment adherence and linkage to community-based HIV care. Participants completed a comprehensive baseline assessment that included self-reported HCV status, which we compared with lab-confirmed status.

Results. Of 110 participants, 103 were available for HCV testing and were included in analyses. Twenty participants (19%) self-reported being HCV+ (of which 11% were HCV Ab(+) all of who were HCV RNA(+)). Nine participants reported being HCVnegative and two were HCV Ab(-). Among those who did not report HCV infection, 80 were HCV Ab(-), one had an equivocal Ab result (HCV RNA(-)), and two (both women) were HCV Ab(+) and HCV RNA(+). Overall, self-report and lab results had a moderate agreement (Cohen’s Kappa = 0.60) and lab-confirmed prevalence of RNA(+) was 13%.

Conclusion. The validity of self-reported HCV status among justice-involved persons living with HIV was moderate. Only one-half of persons who reported HCV infection were confirmed to be HCV infected. In addition, two women (2.4%) who did not report HCV infection were found to be infected. These findings support the need for expanded HCV-specific testing, counseling and education among justice-involved persons, with focused attention on justice-involved women who may be at particularly high risk for undiagnosed HCV.

Disclosures. All authors: No reported disclosures.

2238. Immuno­genicity and safety of four-­ vs. three-­standard doses HBV vaccina­tion in HIV­infected persons with isolated anti­Hbc antibody

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Session: 239. HIV and Viral Hepatitis Co-Infection
Saturday, October 6, 2018: 12:30 PM
Background. HIV-infected patients have decreased serological response to HBV vaccination with faster decline of protective antibody (Ab) titer. In those with isolated anti-Hbc Ab, the role of vaccination remains controversial. We, therefore, conducted this study to evaluate the immuno­genicity of four-­standard doses HBV vaccination in HIV-infected adults with isolated anti-Hbc antibody.

Methods. An open-label randomized controlled trial with 1:1 allocation was conducted among HIV-infected patients attending the Infectious Diseases clinic of the Maharaj Nakorn Chiang Mai Hospital, Faculty of Medicine Chiang Mai University, Chiang Mai, Thailand between July and September 2017. Eligibility participants must be 18 years old, taking cART, CD4 ≥ 200 cells/mm³, HIV VL < 20 copies/mL, and positive isolated anti-Hbc Ab. The participants were randomized to receive either three-standard doses HBV (20 µg at Months 0, 1, and 6) or 4-standard doses HBV (20 µg at Months 0, 1, 6 and 12) at months 0, 1, and 6, respectively. GMT of anti-HBs Ab at Week 28 in those doses arm and four doses arm were 63.8 and 209.8 mIU/mL, respectively, P = 0.030. No adverse events were reported. A younger age (<45 years old) and higher nadir CD4 count (>200 cells/mm³) were independently predictive factors of anam­nestic response with the odd ratio (OR) of 17.4 (95% CI 3.0–102.0) and 21.6 (95% CI 2.7–170.4) respectively. No predictive factors of responders at Week 28 were found.

Conclusion. This Thai HIV-infected patients with isolated anti-Hbc Ab, ana­m­nestic response occurred considerably with both regimens, but the majority was still unprotected. Hence, a single dose vaccination is insufficient. The usual three-standard-doses vaccination was highly effective with high response rate.

Disclosures. All authors: No reported disclosures.

2239. Colorectal Cancer Screening Rate and Outcome in HIV-Infected and HIV- Uninfected Individuals

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Session: 240. HIV: Malignancy
Saturday, October 6, 2018: 12:30 PM
Background. As people with HIV live longer, age-appropriate colorectal cancer (CRC) screening will be an increasingly important component of care. However, it remains unclear whether CRC screening guidelines for the general population, which recommend screening of average-risk persons starting at age 50, are appropriate for people with HIV particularly those with advanced HIV disease.

Methods. We compared CRC screening rates and outcomes among HIV-infected and demographically-matched HIV-uninfected subjects in a large integrated health-care system. Using electronic health records, we identified subjects aged 50–75 years during 2016 with no prior CRC screening. We evaluated time to first CRC screen (FIT, sigmoidoscopy or colonoscopy) using Kaplan–Meier estimates, and compared adenoma and CRC prevalence following first sigmoidoscopy or colonoscopy, by HIV status. Adjusted prevalence ratios (PR) accounted for sex, age, race, smoking status, body mass index, and diagnosis of type 2 diabetes or inflammatory bowel disease. Within each group, we excluded subjects who died, moved, or were undiagnosed with HIV during 5 years of health plan enrollment or turning 50 (85.6% vs. 79.1%, P < 0.001). Among those with a sigmoidoscopy or colonoscopy, adenoma was detected in 161 (19.6%) HIV-infected and 1,498 (22.6%) HIV-uninfected subjects (P = 0.048) and CRC was diagnosed in 9 (0.5%) HIV-infected and 70 (1.0%) HIV-uninfected subjects (P = 0.13). We found suggestion of a lower prevalence of adenomas and CRC among HIV-infected subjects, which only reached statistical significance in unadjusted models (unadjusted PR 0.86, 95% CI 0.75–1.00, P = 0.049; adjusted PR 0.89, 95% CI 0.77–1.03, P = 0.134). Lower CD4 count did not increase likelihood of a positive CRC screening result.

Conclusion. In a setting with overall high screening uptake, we found similar adenoma and CRC prevalence in individuals with and without HIV. Our findings suggest that current CRC screening guidelines for the general population are also suitable for the HIV population.

Disclosures. M. Silverberg: Gilead; Grant Investigator, Grant recipient.

2240. Characteristics of Lung Cancer Treatment in Recent ART-era HIV+ Patients Takaaki Kobayashi, MD1; Kimberly Stone, MPH2; Keith Sigel, MD, PhD3; 1Internal Medicine, Mount Sinai Beth Israel, New York, New York; 2Medicine, Ichan School of Medicine at Mount Sinai, New York, New York; 3Department of Medicine, Division of Infectious Disease, Ichan School of Medicine at Mount Sinai, New York, New York

Session: 240. HIV: Malignancy
Saturday, October 6, 2018: 12:30 PM
Background. Human immunodeficiency virus (HIV) infection is independently associated with lung cancer risk. Due to the aging of the U.S. HIV+ cohort, a high prevalence of smoking and lower rates of HIV-related mortality, lung cancer is now a major source of mortality in this group. Little is known about the tolerability of lung cancer treatment in HIV+ persons in the recent antiretroviral therapy (ART) era.

Methods. We identified all HIV+ adults with new diagnosis of lung cancer who were diagnosed with lung cancer between 2005 and 2016 in our New York health system and collected data on treatment of HIV and treatment of lung cancer as well as adverse outcomes from electronic medical charts. We then compared characteristics, treatments and adverse treatment outcomes for HIV+ patients and controls.

Results. Subjects did not differ by HIV status in regards to age and sex (both P > 0.3) but HIV+ were more likely to be black or Hispanic and less likely to be white (P = 0.001). The prevalence of most major comorbidities did not differ by HIV status although chronic kidney disease and chronic hepatitis C infection were more common in HIV group (P = 0.001). There was no difference in histologic subtype or cancer stage of lung cancer by HIV status. Surgery was performed in 65% of HIV+ and 78% of HIV-. Of the 97 patients screened, 54 participants were enrolled and randomized. Thirty-two participants were male (59.3%) with the mean age of 46 years old. Anamnestic response occurred in 25.9% vs. 33.3% in three doses vs. four doses arm respectively (P = 0.551). After vaccination, the response rates at Week 28 were 85.2% in three doses arm vs. 88.9% in four doses arm (P = 0.4); with 64.9% vs. 63.9% being high level responders, respectively (P = 0.172). GMT of anti-HBs Ab at Week 28