patients received treatment through prior authorizations and uninsured through pharmaceutical patient assistance programs. We examined demographics, homelessness, insurance, fibrosis score, substance use, and psychiatric illness, as potential predictors to treatment initiation using univariate and multivariate logistic regression analysis.

Results. Among the 16,363 BBs screened from March 1, 2016 to December 31, 2017, 1,445 (8.8%) were HCV Ab- and 1,038 (72%) had HCV RNA completed. Among the 724 (5%) with confirmed HCV infection, 139 (19%) received LTC with HCV treatment. Of those, 62 (47%) fell in the F0–F2 range and 71 (53%) in the F3–F4 range. Of those 133 patients, 21 also underwent FibroScan. Seventeen (47%) fell in the F0–F2 range, while seven (33%) fell in the F3–F4 range. Of the 21 patients who both had FibroSure and FibroScan testing, 12 (57%) had concordant F3–F4 fibrosis. In our study, more than half of HIV/HCV co-infected patients had discordant scores. Eight had higher fibrosis scores (F3–F4) with FibroSure, while only one had a higher fibrosis score (F3–F4) with FibroScan.

Conclusion. In our study, more than half of HIV/HCV co-infected patients had advanced fibrosis score at the time of HCV treatment. When FibroSure and FibroScan scores were compared, close to half of co-infected patients had discordant results, the preponderance of which had higher FibroSure scores. As early initiation of HCV treatment is crucial to co-infected patients, further studies will need to evaluate the clinical significance of the discrepancy between different non-invasive fibrosis testing systems in co-infected patients.

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2210. An Online Survey of Hepatitis C Testing Attitudes and Practice Habits Among Residents at an Urban Medical Center Jason Zucker, MD1; Caroline Carnevale, FNP, MPH, AAHIVS2; Matthew Scherer, MD3; Alwyn Coblentz, MD3; Magdalena Sobieszczyn, MD, MPH4; Peter Gordon, MD5; and Susan Olender, MD, MS6; 1Adult and Pediatric Infectious Diseases, Columbia University Medical Center, New York, New York; 2New York Presbyterian Hospital, New York, New York; 3Medicine/Infectious Diseases, Columbia Presbyterian Medical Center, New York, New York; 4Columbia University Medical Center, New York, New York; 5Columbia University, New York, New York

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Background. The hepatitis C virus (HCV) is the most common blood-borne infection; treatments are well tolerated, highly effective, and improve health outcomes. A recent blinded seroprevalence study of ED patients identified an undiagnosed HCV prevalence of 3.8%. New York State recently highlighted a strategic plan to reduce the incidence and prevalence of HCV through aggressive testing, linkage, and treatment. To evaluate HCV screening practices, we conducted a survey of resident attitudes and practice habits surrounding HCV screening.

Methods. From August 1, 2017 to April 30, 2018 we conducted an anonymous online survey to examine attitudes about sexual health screening among residents at an upper Manhattan academic medical center. Response rates were 22% (33) for internal medicine (IM), 45% (35) for pediatrics (Peds), and 21% (10) for emergency medicine (EM).

Results. A majority of IM residents (61%) agreed that HCV screening was one of their responsibilities as compared with Peds (23%, P = 0.002) and EM residents (20%). This differed from HHV testing where the majority of residents across disciplines (73, 71, 60%) considered HHV screening to be their responsibility. IM residents were more likely to agree that it is important to screen for HCV in all care settings. However, less than half of them considered HCV screening (42%) or successfully screened (45%) the majority of their eligible patients. Barriers to HCV screening were diverse across specialty groups with the majority of EM residents concerned about inadequate resources (90%) and issues surrounding minority (47%) and black-white (47%) differences. IM residents were concerned about higher priority issues (85%) and time constraints (58%). Peds residents were concerned that HCV testing was outside their scope of practice (69%) and that the prevalence was too low (63%). When informed that one-third of individuals diagnosed with HCV were part of the cohort Peds and EM residents were more likely to consider screening their patients for HCV.

Conclusion. IM residents acknowledged the importance of HCV screening and felt it appropriate to screen in all settings but identified challenges to screening.

Table 1. Proportion of Patients with ≥F3 at Follow-Up Stratified by Baseline Stage

| Baseline Fibrosis | N (%) with ≥F3 at Follow-Up | N (%) with ≥F3 at Follow-Up |
|-------------------|-----------------------------|-----------------------------|
| Follow-Up 1 (Median Time to Scan) | Follow-Up 2 (Median Time to Scan) | Follow-Up 3 (Median Time to Scan) |
| Stages 0-1 | 13 (5.1%) | 17.0 months | 3 (0.4%) | 19.0 months |
| Stage 2 | 41 (20.1%) | 12.7 months | 11 (5.5%) | 20.1 months |

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Background. The accurate diagnosis of hepatitis C virus (HCV)-related fibrosis is crucial for prognosis and treatment decisions. FibroSure and FibroScan are currently the preferred non-invasive methods for determining HCV-related fibrosis. Both methods have been validated for their correlation to the five-level (F0–F4) METAVIR scoring system. However, the correlation between these two tests in HIV/HCV co-infected patients has not been well described. Here, we evaluated the concordance between FibroSure and FibroScan-derived METAVIR results in HIV co-infected patients.

Methods. We performed a retrospective cross-sectional study of HIV/HCV co-infected patients that were treated between 2014 and 2017 at Drexel University, Philadelphia, PA. We described patient demographics and overall METAVIR scores of treated patients. Further, we compared the concordance between FibroSure and FibroScan results among patients who had both tests before the start of HCV treatment.

Results. One hundred and thirty-eight HIV/HCV co-infected patients were treated. Most of them (N = 134, 97%) achieved sustained virologic response after 12 weeks of treatment. One hundred and thirty-three patients underwent FibroSure testing before starting HCV treatment. Of those, 62 (47%) fell in the F0–F2 range and 71 (53%) in the F3–F4 range. Of those 133 patients, 21 also underwent FibroScan. Seventeen (47%) fell in the F0–F2 range, while seven (33%) fell in the F3–F4 range. Of the 21 patients who both had FibroSure and FibroScan testing, 12 (57%) had concordant F3–F4 fibrosis. Of the patients with discordant results, eight had higher fibrosis scores (F3–F4) with FibroSure, while only one had a higher fibrosis score (F3–F4) with FibroScan.

Conclusion. In our study, more than half of HIV/HCV co-infected patients had advanced fibrosis score at the time of HCV treatment. When FibroSure and FibroScan scores were compared, close to half of co-infected patients had discordant results, the preponderance of which had higher FibroSure scores. As early initiation of HCV treatment is crucial to co-infected patients, further studies will need to evaluate the clinical significance of the discrepancy between different non-invasive fibrosis testing systems in co-infected patients.

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