Disclosures. All authors: No reported disclosures.

2254. Adherence to Cardiovascular Disease Risk Management Guidelines Amongst HIV Providers at an Academic HIV Clinic

Jennifer Veltman, MD1; Eric Walton, BS2; and Veronica Vigilar, BS3; Internal Medicine, Wayne State University School of Medicine, Detroit, Michigan, Wayne State University School of Medicine, Detroit, Michigan.

Session: 241. HIV: Metabolic, Cardiovascular, and Renal Complications
Saturday, October 6, 2018: 12:30 PM

Background. Cardiovascular disease (CVD) among HIV-infected individuals contributes significantly to morbidity and mortality, accounting for one third of non-AIDS defining illness and 11% of deaths. Compared with the general population, HIV-infected individuals are known to have elevated risk for CVD with chronic infection, regardless of HIV RNA levels and studies suggest that clinicians are not appropriately managing ASCVD risk in HIV-infected patients.

Methods. This retrospective cross-sectional study evaluated provider adherence to American College of Cardiology and American Heart Association guidelines for cardiovascular risk assessment and management, as well as risk factors associated with inadequate management. Data were extracted from electronic medical records at a single institution in Detroit, Michigan. Criteria for inclusion were >39 years of age, HIV infected, and clinic visit during June 2017.

Results. Of 209 patients evaluated at the infectious disease clinic, 175 (84%) qualified per guidelines for statin therapy. Only 44% of all patients meeting criteria were taking a statin. Statin users were older and more likely to be nonsmokers than nonusers (P < 0.0022). Amongst patients on statin therapy, 77% receive appropriate intensity therapy; these patients tend to be older (P = 0.0212) and receive a high intensity regimen (P < 0.0001). CD4 count and viral load were not associated with statin eligibility or appropriate intensity therapy.

Conclusion. Despite high rates of patients qualifying for statin therapy, a majority of patients do not receive statins to manage cardiovascular disease risk. Of note, patients at elevated risk for cardiovascular disease due to smoking are less likely to receive therapy. However, amongst patients receiving statin therapy, treatment tends to be appropriate, especially with older patients on high intensity therapy.

Disclosures. J. Veltman, Janssen: Speaker’s Bureau, Speaker honorarium.

2255. Fibroblast Growth Factor 23, a Potential Risk Factor for Cardiovascular Disease Is Associated with Abacavir/Lamivudine Use in HIV Patients

Yuuke Yoshino, MD; Ketta Misu, MD; Takanori Kitazawa, MD; and Yauko Ota, MD; Infectious Diseases, Teikyo University School of Medicine, Tokyo, Japan.

Session: 241. HIV: Metabolic, Cardiovascular, and Renal Complications
Saturday, October 6, 2018: 12:30 PM

Background. The fibroblast growth factor (FGF) 23 is a hormone-like molecule that secretes from osteoblasts and has the function of suppressing the reabsorption of phosphorus in the distal renal tubule and lowering serum phosphorus. It has been shown that renal dysfunction increases serum FGF23 levels. Although the mechanism remains to be determined, it is also reported that the elevation of serum FGF23 might increase the risk of coronary vascular diseases (CVD). Nevertheless, there are very few reports related to FGF23 in patients with HIV. The goal of the present study was to investigate the relationship between serum FGF23 levels and clinical factors in HIV patients.

Methods. Male HIV patients who visited the outpatient clinic of Teikyo University Hospital, Tokyo, Japan in 2015 and had been treated with anti-retroviral therapy for more than six months were enrolled. In addition to serum FGF23, clinical factors were also specified, including age, ART regimen, and Framingham Coronary Heart Disease Risk Score (FHS). To study correlations with FGF23, spearman coefficients was used. To identify factors independently related with serum FGF23, multiple regression analysis was used.

Results. Sixty-seven patients were enrolled. The median age was 43.7 years old. Median CD4 cell counts was 529/μl, and the median serum FGF23 level was 36.0 pp/ml. According to spearman coefficients, serum FGF23 levels correlated with HIV RNA > 50 copies (r = 0.3911, P = 0.0011), serum cystatin C level (r = 0.3399, P = 0.0097), and some management, including age, ART regimen, and laboratory data, and Framingham Coronary Heart Disease Risk Score (FHS). To study correlations with FGF23, spearman coefficients was used. To identify factors independently related with serum FGF23, multiple regression analysis was used.

Conclusion. Poor virological control and ABC/3TC use were significant factors that elevated serum FGF23 levels. Considering that ABC/3TC is a well-known factor in the increase of the risk of CVD, FGF23 might be one of the factors that increases the risk of CVD in HIV patients receiving ABC/3TC, though FGF23 was not significantly related with FHS in our all study patients.

Disclosures. All authors: No reported disclosures.

2256. Racial Differences in Dyslipidemia Clinical Characteristics and Treatment Among Urban HIV Patients

Zhengyao Ouiborh, MPH1,2; Christine Joseph, PhD3 and John McKinnon, MD, MSc4; Medicine - Infectious Diseases, Henry Ford Hospital, Detroit, Michigan, Henry Ford Health System, Detroit, Michigan, Medicine/Infectious Diseases, Henry Ford Hospital, Detroit, Michigan.

Session: 241. HIV: Metabolic, Cardiovascular, and Renal Complications
Saturday, October 6, 2018: 12:30 PM

Background. Racial and ethnic minorities comprise an increasing proportion of the US population, and are disproportionately affected by HIV. Dyslipidemia is a key comorbidity in HIV due to high prevalence and demonstrated racial disparities in testing and treatment among non-HIV patients. Previous analysis has shown that HIV-positive African American (AA) patients were less likely to have had a lipid profile done and less likely to have been diagnosed with dyslipidemia than other racial groups.

Methods. Electronic medical records (EMR) identified 1,457 HIV patients from the HIV clinic at Henry Ford Hospital, Detroit, Michigan from March 2013 to November 2015. Race/ethnicity and gender were identified by self-report and then a retrospective EMR review of patients tested for, and documented ICD-9 codes for dyslipidemia was done. Descriptive analyses and group comparisons were performed between AA and other racial/ethnic groups.

Results. 1,220 HIV patients had lipid levels tested with 25.7% having dyslipidemia after HIV diagnosis. Among those, it was found that lipid abnormalities varied by race; on average, Hispanics, had lower total cholesterol (P = 0.040). AA patients had lower triglycerides (P < 0.001), and White patients had higher triglycerides (P > 0.001). HDL levels were higher in AA patients and lowest in White patients (P < 0.001), while Hispanics had lower LDL values (P = 0.009). There was no statistically significant difference (P > 0.19) between the lipid lowering prescribed by race, and the type of dyslipidemia was the primary predictor of LLD provided to the patients (P < 0.001). Patients prescribed fibrates were statistically more likely to have met their ATP III treatment goals at 1 year as compared with statins, regardless of race (P < 0.001). Only 41% of odds of meeting treatment goals were 54% (OR 0.46, CI 0.26-0.71) less among AA patients regardless of medication.

Conclusion. Dyslipidemia is prevalent in our HIV population. Racial differences in testing, lipid abnormalities and treatment outcomes among these vulnerable HIV minorities necessitate further investigations to close the gaps in care and improve our management of dyslipidemia for our HIV patients.

Disclosures. All authors: No reported disclosures.

2257. Noninfectious Comorbidities Associated With High RWID in HIV-Infected Patients: A Cross-Sectional Study in Miami, Florida

Javier Buez Presser, MD1; Mohammed Raja, MD2; Marco Loriog Rugama, MD3; Ana Milisavljevic, MD4; and Jose Gonzales Zamora, MD5; Infectious Diseases, University of Miami/Jackson Memorial Hospital, Miami, Florida, *Internal Medicine, University of Miami/Jackson Memorial Hospital, Miami, Florida.

Session: 241. HIV: Metabolic, Cardiovascular, and Renal Complications
Saturday, October 6, 2018: 12:30 PM

Background. Red blood cell distribution width (RDW) is a hematologic parameter that may reflect an underlying inflammatory state. It has been linked to cardiovascular disease, metabolic syndrome and increased mortality in the general population. However, little is known about the comorbidities associated with high RDW in HIV-infected patients.

Methods. We conducted a retrospective review of HIV-infected patients treated in the Ryan White Clinic of Jackson Memorial Hospital from January to December 2016. Of the 2,065 patients who attended our clinic in 2016, a sample of 317 patients was obtained. Our aim was to determine the noninfectious comorbidities associated with high RDW (≥114%) in patients with undetectable HIV viral load. Data were analyzed in SPSS 22, New York, USA.

Results. Our study included 317 HIV patients with undetectable HIV viral load, 123 (38.8%) females and 194 (61.2%) males with a mean age of 54.3 (SD ±9.94). Most patients were African American (52.4%) and Hispanic (39.4%). The mean CD4 count was 609.9 cells/μl (SD ±303.48) with a mean CD4/CD8 ratio of 1.04 (SD ±2.38). The mean RWID was 13.6% (SD ±2.08). High RWID was observed in 94 (29.7%) patients. Hepatitis B and C coinfection were found in 7.6% and 11.4% of patients, respectively. 74 (23.3%) patients reported alcohol use and 103 (32.5%) patients disclosed smoking. Most patients were on antiretroviral therapy (98.4%), the preferred regimen was 2 NRTIs plus an integrase inhibitor (53%). The most frequent noninfectious comorbidities were dyslipidemia (56.8%), hypertension (52.4%), depression (28.6%) and diabetes mellitus (19.6%). In comparison with the rest of the study cohort, the patients with high RWID had a higher proportion of hypertension (61.7% vs. 48.4%, P = 0.031), stroke (7.4% vs. 0.9%, P = 0.001), congestive heart failure (10.6% vs. 2.7%, P = 0.003) and chronic kidney disease (26.6% vs. 10.3%, P < 0.001). They also had significantly lower CD4 count (555.8 vs. 652.7, P = 0.039). No difference was found in myocardial infarction, peripheral vascular disease, dementia, COPD, asthma, cancer, liver disease, dyslipidemia, anemia or gastric disease.

Disclosures. All authors: No reported disclosures.