2251. Comparing Statin Prescribing Rates in Eligible HIV vs. Non-HIV-Infected Patients
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Table 1:

| Value | Co-infected | HCV | HIV | PValue |
|-------|-------------|-----|-----|--------|
| PCE   | Ref         | 0.00 (-0.14, 0.10) | -0.07 (-0.17, 0.04) | 0.52 |
| FRS   | 0.15 (0.01, 0.20) | 0.03 (-0.07, 0.13) | 0.11 |
| D:A:D | Ref         | NA  | 0.05 (-0.06, 0.16) | 0.36 |

2253. Comparison of Cardiovascular Risk in Patients Infected With HIV and Hepatitis C
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Background. HIV and hepatitis C virus (HCV) are independently associated with poorer cardiovascular and metabolic outcomes compared with the general population. Evidence remains mixed on how these contribute to cardiovascular disease (CVD) risk in co-infection. Prior studies mainly studied established risk models in mono-infected groups or lacked recent scores like Pooled Cohort Equations. This study assesses CVD risk using established risk models and statin usage for primary prevention in matched co-infected and mono-infected cohorts.

Methods. Retrospective chart review of HIV and/or HCV-infected subjects = 18 years seen from January 1, 2014 to December 31, 2016 at Washington University Infectious Disease or Hepatology clinics. Patients included if lipid panel available before statin usage and excluded for prior CVD. Patients matched by gender, age, and race/ethnicity. CVD risk assessed with Framingham general CV Risk Score (FRS), ACC/AHA Pooled Cohort equations (PCEs), and Data Collection on Adverse Effects of Anti-HIV Drugs (D:A:D) HIV model. Multivariate linear models evaluated CVD risk after log-transforming skewed data.

Results. Each infection group (HIV, HCV, HIV/HCV) had 192 matched subjects. Most were male (76.7%) and African American (73.7%) with overall mean age 51.2 ± 8.6 years. CVD risk did not differ among infection groups with PCE, FRS, and D:A:D most likely to be prescribed a statin. No association was observed between prescribed statin and HIV status in each of the benefit groups. HCV-related factors may not be fully captured in these scores. Statin uptake remains lower in HIV cohorts but higher in patients with diabetes and dyslipidemia.

Conclusion. CVD risk scores did not differ among HIV/HCV co-infected and respective mono-infected cohorts. CVD risk may be underestimated as specific HIV and HCV-related factors may not be fully captured in these scores. Statin uptake remains low in HIV patients despite recent primary prevention guidelines.

Figure 1: (a–c) Ten-year CVD risk models across infection groups based on model specific definitions of risk cutoff. D:A:D distribution extrapolated from 5-year risk score assuming constant risk over 10 years for ease of comparison.
2254. Adherence to Cardiovascular Disease Risk Management Guidelines Amongst HIV Providers at an Academic HIV Clinic
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Background. Cardiovascular disease (CVD) amongst HIV-infected individuals contributes significantly to morbidity and mortality, accounting for one of the 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 suggests 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 patients (84%) qualified per guidelines for statin therapy. Only 44% of these patients are 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). CV disease and viral load were not associated with statin eligibility or appropriate therapy intensity.

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
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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 be associated with high RDW (P = 0.039). We hypothesized that high FGF23 levels might be associated with cardio metabolic disease in HIV patients.

Methods. We conducted a retrospective review of HIV-infected patients treated at 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 FGF23 in HIV-infected patients.

Results. We conducted a retrospective review of HIV-infected patients treated at 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 FGF23 in HIV-infected patients.

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 RDW in HIV-Infected Patients: A Cross-Sectional Study in Miami, Florida
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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 at 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 (241%) 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 698.9 cells/μL (SD ±303.48) with a mean CD4/CD8 ratio of 1.04 (SD ±0.38). The mean RDW was 13.6% (SD ±2.08). High RDW 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 105 (32.5%) patients smoked tobacco. Most patients were on antiretroviral therapy (98.4%) and the preferred regimen was 2 NRTIs plus an integrase inhibitor (53%). The most frequent noninfectious comorbidities were dyslipidemia (56.8%), hypertension (52.4%), depression (26.8%) and diabetes mellitus (19.6%). In comparison with the rest of the study cohort, the patients with high RDW 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 = 0.03) 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, liver disease, dyslipidemia, anemia, or gastric disease.

Disclosures. All authors: No reported disclosures.