Table: Patient characteristics, DAA regimen and outcomes

| Gender | Age | Malignancy | Genotype | Fna-sal. DAA | Duration (weeks) | Virologic outcome | SVR24 | Relapse |
|--------|-----|------------|-----------|--------------|-----------------|------------------|-------|---------|
| M      | 56  | No         | SOF/LDV   | 24           | No              | Relicense        | Yes   | No      |
| M      | 87  | No         | SOF/LDV   | 24           | No              | Relicense        | Yes   | No      |
| M      | 87  | No         | SOF/LDV   | 24           | No              | Relicense        | Yes   | No      |
| M      | 66  | No         | SOF/LDV   | 24           | No              | Relicense        | Yes   | No      |
| M      | 56  | No         | SOF/LDV   | 24           | No              | Relicense        | Yes   | No      |
| M      | 63  | No         | SOF/LDV   | 24           | No              | Relicense        | Yes   | No      |
| M      | 66  | No         | SOF/LDV   | 24           | No              | Relicense        | Yes   | No      |
| M      | 66  | No         | SOF/LDV   | 24           | No              | Relicense        | Yes   | No      |

544. Retreatment of Chronic HCV Infection after Second Generation DAA Failure in Patients in the NJ VA Healthcare System

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Session: 59. Hepatitis B and C in Varied Settings Thursday, October 5, 2017: 12:30 PM

Background. The data on retreatment of patients with second-generation DAA treatment failure is limited. AASLD retreatment guidelines were established but are classified as class IIb-Level C. We analyzed treatment outcomes in NJ VA patients with prior second-generation DAA failure over a period of 1 year.

Methods. We performed a retrospective health record review of all HCV patients treated between May 1, 2016 and May 1, 2017. HCV genotypes (GT), the presence of cirrhosis and HIV, DAA type, and RAVs post treatment were evaluated in the treatment failure (TF) group, defined as an inability to achieve the sustained virologic response. Post-treatment resistance panel was available for 2/10 patients with the following detected mutations: Q30H/K/R, L31M/L, Q20Q, D168E, Y93A/H. All 10 patients had an undetectable viral load (VL) at the end of treatment. SVR12 has been achieved for all 5 patients that were tested, with the remaining 5 awaiting week 12.

Conclusion. The HCV second-generation DAA treatment failure rate in patients at the NJ VA HCS over 1 year was 3.2%. Analysis of available data indicates that the presence of RAVs might be the major cause of treatment failure among HCV patients treated with DAAAs in NJ VA. Different retreatment regimens were used for a period of 12–24 weeks with 100% undetectable VL at end of treatment.

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545. Assessing Gaps in Hepatitis C Care in Primary Care

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Background. Prevention of Hepatitis C virus (HCV) infection and its associated health complications are a national priority. To achieve optimal health outcomes, people with HCV must receive the diagnosis, link to and retain in care and receive treatment. Despite recent progress in increasing capacity and improving access to care for patients with HCV in the United States, there continues to be a need to improve Hepatitis C care especially in primary care settings. This study sought to assess HCV care in a resident-run primary care clinic of a community hospital.

Methods. Retrospective study of active patients ≥18 years with a diagnosis of Hepatitis C, in the electronic medical records (EMR) at 2 outpatient medical clinics at a community hospital in Rhode Island. Patients were identified by searching the following diagnoses in the EMR: “chronic hepatitis C”, “chronic hepatitis C without coma”, “chronic hepatitis C with coma”, “reactive HCV serology”, “hepatocellular carcinoma”. Patients with HIV co-infection were excluded as these patients are usually referred to a specialty clinic outside the hospital’s network.

Results. Out of 12,482 outpatients, 306 had a diagnosis of Hepatitis C. One hundred and fifty-nine (54%) of these patients had HCV RNA detected indicating chronic infection. 51 (17%) patients had reactive HCV antibodies and undetected HCV RNA indicating past infection, and 84 (29%) patients had positive serology to HCV but lacked HCV RNA testing. Obesity was associated with not having HCV RNA checked (OR 2.9, 95% CI 1.66-5.24). No differences observed for other variables although patients with a history of alcohol use had a tendency towards lacking HCV RNA testing (P = 0.08). The prevalence of confirmed chronic hepatitis C was 1.6%. Twenty-three (23%) patients with chronic hepatitis C had cirrhosis and 5 had hepatocellular carcinoma however only a minority of them (11%) had received or were receiving direct acting antivirals. Hepatitis B vaccination in HCV infected patients was low (39%).

Conclusion. A significant proportion of patients with reactive serology to HCV in our primary care clinics miss the critical step of having HCV RNA checked. Other medical conditions such as obesity may take priority over HCV care. Implementation of HCV targeted interventions could improve HCV care in primary care.

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546. Direct-acting Antivirals Induce Lymphoproliferative Disease Response in HCV-infected Patients: A Prospective Case Series

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Background. Hepatitis C virus (HCV) infection is associated with the development of B-cell Non-Hodgkin lymphoma (NHL). Several studies report regression of indolent NHL in HCV-infected patients treated with interferon (IFN)-containing therapy without chemotherapy. We are describing, herein, the oncologic response of patients with such cancers treated with only direct antiviral agents (DAAs).

Methods. Patients with HCV-associated NHL seen at MD Anderson Cancer Center (6/2014 to 6/2017) and treated with DAAs were followed and those with indolent NHL treated with DAAs were further analyzed. DAA regimens were administered according to guidelines for HCV-infected patients without cancer. Efficacy was calculated on the basis of achieving sustained virologic response 12 weeks (SVR12) after end of treatment (EOT). NHL status was evaluated at the time of DAAs initiation and response was prospectively analyzed at 6 months after EOT using WHO criteria.
Results. Six patients received DAAs alone as first-line management of their NHL. Most patients 5/6 (83%) did respond to such treatment avoiding or delaying the use of chemotherapy (Table).

Conclusion. As described with IFN-containing therapy, the oncologic outcome of HCV-infected patients with indolent NHL could also improve by using only DAAs.

Table: Characteristics of six patients with indolent NHL treated with DAAs.

| Characteristic                  | Number of patients (%) |
|--------------------------------|------------------------|
| Gender, male                   | 4 (67)                 |
| NHL subtype                    | 1 (17)                 |
| Marginal zone lymphoma         | 6 (100)                |
| HCV genotype                   | 1 (17)                 |
| 1                              | 3 (50)                 |
| 2                              | 3 (50)                 |
| rs12979860 genotype            | 0                     |
| CC                             | 2 (33)                 |
| CT                             | 3 (50)                 |
| TT                             | 1 (17)                 |
| Cirrhosis                      | 0                     |
| History of HCV treatment       | 0                     |
| DAA therapy                    | 2 (33)                 |
| Sofosbuvir + ribavirin          | 1 (17)                 |
| Sofosbuvir + simeprevir         | 1 (17)                 |
| Sofosbuvir + daclatasvir        | 2 (33)                 |
| Sofosbuvir + ledipasvir         | 1 (17)                 |
| DAA treatment duration of 12 weeks | 6 (100)             |
| NADH response after SVR        | 2 (33)                 |
| Partial response               | 1 (17)                 |
| Stable disease                 | 2 (33)                 |
| Persistent disease             | 1 (17)                 |
| Chemotherapy needed after SVR  | 3 (50)                 |

Abbreviations: IQR, interquartile range; NHL, Non-Hodgkin lymphoma; HCV, hepatitis C virus; DAAs, direct acting agents; SVR, sustained virologic response; *Nodal (n = 1), Extranaod (n = 2) splenic (n = 1), and mucosa-associated lymphoid tissue lymphomas (n = 2); Formerly known as interleukin 28b genotype.

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547. Incidence of Symptomatic CSF Viral Escape in HIV-infected Adults Receiving Atazanavir/Ritonavir (ATV/r)-Containing ART: A Tertiary Care Cohort in Western India

Table: Characteristics of patients receiving ATV/r-containing ART.

| Characteristic                  | Number of patients (%) |
|--------------------------------|------------------------|
| Median age (IQR), years        | 60 (55-65)             |
| Gender, male                   | 4 (67)                 |
| NHL subtype                    | 1 (17)                 |
| Marginal zone lymphoma         | 6 (100)                |
| HCV genotype                   | 1 (17)                 |
| 1                              | 3 (50)                 |
| 2                              | 3 (50)                 |
| rs12979860 genotype            | 0                     |
| CC                             | 2 (33)                 |
| CT                             | 3 (50)                 |
| TT                             | 1 (17)                 |
| Cirrhosis                      | 0                     |
| History of HCV treatment       | 0                     |
| DAA therapy                    | 2 (33)                 |
| Sofosbuvir + ribavirin          | 1 (17)                 |
| Sofosbuvir + simeprevir         | 1 (17)                 |
| Sofosbuvir + daclatasvir        | 2 (33)                 |
| Sofosbuvir + ledipasvir         | 1 (17)                 |
| DAA treatment duration of 12 weeks | 6 (100)             |
| NADH response after SVR        | 2 (33)                 |
| Partial response               | 1 (17)                 |
| Stable disease                 | 2 (33)                 |
| Persistent disease             | 1 (17)                 |
| Chemotherapy needed after SVR  | 3 (50)                 |

548. Stroke Outcomes Among HIV-infected Patients in a Large, Urban, Tertiary Hospital in the USA, 1999–2016

Results. Of 20,268 patients, 81 were HIV-infected. The median CD4+ count was 148 cells/µL and 38% had HIV viral load < 200 copies/mL at stroke presentation. Compared with HIV-uninfected patients, HIV-infected patients were significantly younger (49 vs. 65 years, P = 0.010) and had higher rates of smoking, alcohol and illicit drug use (table). Comorbid conditions, stroke severity, length of hospital stay, and rates of inpatient mortality and hospital complications between the two groups were similar. The proportion of stroke admissions among HIV-infected patients peaked in 2010–2011 (figure). From 1999 to 2016 were included. Variables between groups were compared using independent samples t-test or the Wilcoxon rank-sum test for continuous variables and the chi-square or Fisher’s exact test for categorical variables when applicable. Spearman’s test was used for correlation analyses.

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