diagnosed in 2002–2006 (3.0 [2.0–4.7]). 281 (23.2%) had an AIDS-defining diagnosis (CD4<200 cells/μL in 88%), which decreased by era (P<0.05). There were 6 deaths in the cohort, all prior to 2012.

**Conclusion.** Universal HIV testing and open access to care has resulted in excellent outcomes for AD-HIV-positive military members. The MHS model reinforces the benefits of the Department of Health and Human Services’ recommendations for universal testing, linkage to care and ART.

---

**1264. Characterization of HIV-Positive Patients with Low-Level Viremia in a Community HIV Clinic Between 2014 and 2018**

Eduardo Sanchez, MD; Jody Borgman, MD; Aviva Joffe, MSW, LSW; Catherine Holdsworth, PhD, CRNP; Albert Einstein Medical Center, Philadelphia, Pennsylvania

**Session:** 148. HIV: General Epidemiology  
**Friday, October 4, 2019: 12:15 PM**

**Background.** Low-level viremia (LLV) has been defined as an HIV RNA level detectable by newer generation viral load quantification assays but that is ≤200 copies/ml. Contributing factors may include intermittent low-level releases of virus from existing reservoirs, random laboratory variation and decreased ART adherence.

**Methods.** This retrospective chart review aimed to characterize patients who developed LLV in a community HIV clinic between 2014 and 2018. LLV was defined as two consecutive detectable HIV RNA measurements ≤200 copies/mL. Possible factors that could be associated with viral rebound (VR), defined as an HIV RNA >200 copies/ml, were evaluated by using multivariate logistic regression.

**Results.** Of a total of 666 patients, 111 met criteria for LLV. Seventy-seven were male and 34 were female. The majority were African American (85.6%) with Hispanic and white accounting for 5.4% each. Fifty-five percent were heterosexual and 34 were female. The majority were African American (85.6%) with Hispanic and white accounting for 5.4% each. Fifty-five percent were heterosexual and 34.5% were men that have sex with men. Analyzing CD4 counts at the moment or just prior to the development of LLV, 42 of them (37.8%) had a CD4 between 501 and 800 cells/mm². Twenty (20.3%) of the 59 developed VR. HIV RNA levels between 51 and 100 copies/mL and 101 and 200 copies/mL were associated with viral rebound (VR), defined as an HIV RNA >200 copies/ml, were evaluated by using multivariate logistic regression.

**Conclusion.** This community HIV clinic has a low prevalence of LLV. Most of the patients did not develop VR. Although some clinical factors were found to be associated with viral rebound in patients with LLV, the associations did not achieve statistical significance. LLV is a phenomenon that requires further research, specifically regarding predictors of VR, particularly now in the INSTI era.

**Disclosures.** All authors: No reported disclosures.

---

**1266. Cancer among HIV-Positive Patients in Cali, Colombia: A Retrospective Hospital-Based Study**

Claudia M. Parra, MD; Juan Carlos Bravo, MD; Luis Eduardo Bravo, MD; Fernando Rosso, MD; M Sc; Fundación Valle del Lili, Cali, Valle del Cauca, Colombia; Universidad del Valle, Cali, Valle del Cauca, Colombia

**Session:** 148. HIV: General Epidemiology  
**Friday, October 4, 2019: 12:15 PM**

**Background.** Cancer has been a significant feature of the HIV epidemic from the beginning, being the most frequent Kaposi sarcoma (KS) and hematolymphoid malignancies. However, the behavior of these two diseases is limited in our context. This study aimed to determine the trends of cancer among HIV/AIDS patients between 2011 and 2016.

**Methods.** A retrospective hospital-based study was conducted at Fundación Valle del Lili, Cali, Colombia. The study included HIV-positive patients diagnosed with cancer. HIV registry was cross-linked with a population-based cancer registry to obtain IARC/WHO ICD-O-3 classification and follow-up information on all patients. A descriptive analysis of the variables was performed. Survival analysis was carried out using the Kaplan–Meier method. Differences between cancer survival were assessed through the log-rank test.

**Results.** From 2,051 HIV-positive patient’s records between 2011 and 2016, 95 patients were diagnosed with cancer after HIV infection. The median age was 43 years (IQR=33–57), and 88% were male. Types of cancer were: Kaposi sarcoma 17%, hematolymphoid malignancies 21% and other cancer 62%. The probability of cancer diagnosis after HIV was 77% (CI 95% [64.76–86.81]) at 5 years follow-up, since HIV diagnostic. Hematolymphoid malignancies and KS survival were 50% (CI 95% [20.85–73.61]) and 65.63% (CI 95% [35.80–84.14]) at 5 years follow-up, respectively. There was a statistically significant difference between KS, hematolymphoid and other cancer cases survival (P = 0.0178).

**Conclusion.** This study showed the role of HIV in cancer survival for KS and hematolymphoid malignancies mainly, in a developing country. It is necessary to join efforts in our context to reduce HIV cases and associated malignancies.

**Disclosures.** All authors: No reported disclosures.

---

**1267. Contribution of Acute Infection to the Community Viral Load of an HIV Care Program**

Eleanor Friedman, PhD; Jessica Schmitt, LCSW; David Pitrak, MD; University of Chicago Medicine, Chicago, Illinois

**Session:** 148. HIV: General Epidemiology  
**Friday, October 4, 2019: 12:15 PM**

**Background.** Individuals with acute HIV infection (AHI) are a priority for public health due to higher viral loads and greater risk of transmission. Despite potential clinical and public health benefits, rapid or immediate ART can be resource-intensive, with programmatic implications. We measured the contribution of AHI to our programs community viral load (VL) to inform our expanded testing and linkage to care program.
Methods. We calculated the contribution to the community VL for 3 HIV-positive groups from January 1, 2016 to September 1, 2018: (1) AHI (p24 antigen-positive, negative or indeterminate supplemental antibody testing), (2) new diagnoses (ND), and (3) existing diagnoses (ED). Persons who were AHI or ND were ART naive at first VL. The contribution of each group to community VL was calculated at the first and second VL assays. Group contributions were characterized as (1) percentage of the total HIV-positive population, and (2) group contribution to community VL.

Results. 217 persons tested positive for HIV and had an initial VL, and 69 persons linked to our program had a second VL. Time intervals between first and second VL measurements were similar between groups (Kruskal–Wallis P = 0.55). Initial VL medians were significantly different by group (Kruskal–Wallis P < 0.001), partly due to the large number of ED in care and virally suppressed (<200 copies/mL) at first VL (n = 82). AHI contributed the fewest persons to the HIV-positive population (7.8%), but contributed the most to first VL (58.6%). ART reduced VL for all groups. The median time from diagnosis to treatment for AHI was 5.5 days (IQR 4–21). Due to both natural decay and ART, AHI contributed the least to total VL load at second assay (5.6%). Using previously published data on treated and untreated VL decay, a delay in ART of 15 days would result in an estimated VL of 17,721 copies/mL (95% confidence interval 537–53,576) vs. the estimated VL with ART, 131 copies/mL (95% CI 5–294), a 135-fold increase in AHI VL.

Conclusion. Patients with AHI are small proportion of our cohort compared with ND and ED, but account for the greatest portion of our community VL. These data quantify the benefit of rapid initiation of ART for AHI to reduce community VL, a priority for prevention efforts.

Disclosures. All authors: No reported disclosures.

Fig 1. ACEs Prevalence by Score (n=49)

Fig 2. ACEs Prevalence by Experience Type (n=49)

1269. Cohort Profile: The Translational Platform HIV (TP-HIV), a Multicenter Cohort Project in Germany

Melanie Stecher, Msc Public Health 1; Jan–Christian Wasmuth, MD 2; Elena Knops, DV 3; Anna Eis-Hübing, MD 4; Johannes Bogner, Prof 5; Christoph Spinnler, MD 6; Josef Eberle, Prof 7; Clara Lehmann, MD 8; Olaf Degen, MD 9; Jürgen Rockstroh, Prof 10; Markus Altötter, Prof 11; Timo Wolf, MD 12; Matthias C. Mueller, MD 13; Stefan Scholten, MD 14; Christoph Weyn, MD 15; Heiko Jessen, MD 16; Nils Postel, MD 17; Ramona Pauli 18; Eva Wolf, MD 19; Johanna Eger, MD 20; Guido Schäfer, MD 21; Hans-Jürgen Stellbrink, Prof 22; Ivanika Krsnaric, MD 22; Ewa Heger, Dr 23; Ulrich Kastenbauer, MD 24; Georg Behrens, Prof 25; Gerd Falkenheuer, Prof 26; Jörg Vehreschild, Prof 27; University of Cologne, Faculty of Medicine and University Hospital Cologne, Department I for Internal Medicine, Cologne, Nordrhein-Westfalen, Germany; 2Department for Internal Medicine I, University Hospital of Bonn, Bonn, Nordrhein-Westfalen, Germany; 3Institute of Virology, University Hospital of Cologne, Cologne, Nordrhein-Westfalen, Germany; 4Institute of Virology, University of Bonn Medical Center, Bonn, Nordrhein-Westfalen, Germany; 5Internal Medicine IV – University Hospital of Freiburg, Freiburg, Baden-Württemberg, Germany; 6Medical Practice prinzmed, München, Bayern, Germany; 7Muc Research GmbH, Munich, Bayern, Germany; 8Center for Infectious Diseases (ZIMI), Munich, Bayern, Germany; 9University Hospital Hamburg Eppendorf, Hamburg, Germany; 10HIV Center, University Hospital of Frankfurt, Frankfurt, Hessen, Germany; 11Division of Infectious Diseases, Department of Medicine II, University Medical Center Freiburg, Freiburg, Baden-Württemberg, Germany; 12Medical practice Hohenstaufenring, Köln, Nordrhein-Westfalen, Germany; 13Medical practice Ebertplatz, Cologne, Nordrhein-Westfalen, Germany; 14Medical Practice Jessen 21, Berlin, Germany; 15Medical Practice prinzmed, München, Bayern, Germany; 16Medical Practice Prinzmed, München, Bayern, Germany; 17Stefan Scholten, MD 21; 18Heiko Jessen, MD 21; 19Johanna Eger, MD 20; 20Guido Schäfer, MD 21; 21Hans-Jürgen Stellbrink, Prof 22; Ivanika Krsnaric, MD 22; 22Eva Heger, Dr 23; Ulrich Kastenbauer, MD 24; 23Georg Behrens, Prof 25; 24Gerd Falkenheuer, Prof 26; 25Jörg Vehreschild, Prof 27; 26University of Cologne, Faculty of Medicine and University Hospital Cologne, Department I for Internal Medicine, Cologne, Nordrhein-Westfalen, Germany; 27Institute of Virology, University Hospital of Cologne, Cologne, Nordrhein-Westfalen, Germany; 28Center for Infectious Diseases Berlin (zibi), Berlin, Germany; 29Medical Practice Freiburg, Baden-Württemberg, Germany; 30University Hospital Hamburg Eppendorf, Hamburg, Germany; 31ICH-Gründl, Hamburg, Germany; 32Center for Infectious Diseases Berlin (zibi), Berlin, Germany; 33University Hospital of Cologne, Cologne, Nordrhein-Westfalen, Germany; 34Hannover Medical School, Hannover, Niedersachsen, Germany; 35University Hospital of Cologne, Cologne, Nordrhein-Westfalen, Germany.