lost to follow up and SVR status was unknown. At the time of collection 5/64 (7.8%) patients had pending SVR12 results.

**Conclusion.** While the literature demonstrates that patients of AA background have lower rates of SVR12, our data states that there was no statistical difference when looking at race and outcome: Limitations in our study included a smaller population, as well as a significantly population that was lost to follow up.

**Disclosures.** Y. Bennani, Gilead: Investigator, Grant recipient; G. Therapondos, Gilead: Investigator and Scientific Advisor, Consulting fee and Research support; C. Parsons, Gilead: Investigator, Grant recipient

2230. Sustained Virologic Response with Direct Acting Antivirals in HIV Coinfected Hepatitis C Patients and Its Effect on Liver Fibrosis

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**Session:** 245. HIV and HCV Saturday, October 7, 2017: 12:30 PM

**Background.** Hepatitis C virus (HCV) is an important cause of chronic hepatitis resulting in end stage liver disease and hepatocellular carcinoma. Direct acting antivirals (DAAs) interfere with the HCV lifecycle and result in high rates of sustained virologic response (SVR). We hypothesized that treatment with DAAs in a real world setting would result in successful treatment of HCV/HIV coinfected patients as it is in HCV monoinfected patients, and that some degree of fibrosis regression can be observed after completion of therapy in both groups.

**Methods.** We retrospectively reviewed data from patients who received treatment for HCV from 2014 to 2016 at the Infectious Diseases clinic and collected demographic characteristics, HCV genotype and viral load, DAA regimen, SVR rates, and whether or not fibrosis improved at 12 or 24 weeks after treatment completion defined as one META VIR stage improvement in FibroSURE™ score to estimate fibrosis.

In those with HIV, HIV viral load, CD4 count and HIV antiretroviral regimen were examined.

**Results.** Out of 41 patients in each group, 24 had completed therapy in the monoinfected group and 26 in the coinfect group. In the monoinfected group, 22 (92%) achieved SVR. In the coinfect group, 26 (100%) achieved SVR. The SVR rates of the monoinfected group and coinfect group did not differ significantly (P = .956). In the monoinfected group, 10/17 (59%) had an improvement in FibroSURE™ score, and 7/17 (41%) had no change. In the coinfect group, 2/9 (22%) patients demonstrated an improvement in FibroSURE™ score, 4/9 (44%) had no change, and 3/9 (33%) had an increase in FibroSURE™ score. There was no significant difference in the change in FibroSURE™ score before and after SVR between the two groups (P = .100).

**Conclusion.** In this small study, although not statistically significant, coinfected patients treated with DAAs had higher SVR rates than monoinfected patients. Treatment failure in the monoinfected group was linked to nonadherence, whereas success of the coinfect patients was likely related to engagement in routine HIV care. Although not statistically significant, there were more patients in the monoinfect group that had an improvement in FibroSURE™ score, however the small sample size precludes any definitive conclusions.

**Disclosures.** Y. Bennani, Gilead: Investigator, Grant recipient; G. Therapondos, Gilead: Investigator and Scientific Advisor, Consulting fee and Research support; C. Parsons, Gilead: Investigator, Grant recipient

2231. Hepatitis C Viremia Post Direct Acting Therapy Did Not Correlate with Treatment Failure in HCV/HIV Co-Infected Patients

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**Background.** AASLD/IDSA guidelines recommend 12 weeks of ledipasvir/sofosbuvir for HCV genotype 1 infection treatment. HCV viral load (VL) is measured at baseline, week 4 of treatment, and at end of treatment (EOT). The aim of this study is to describe HCV/HIV patients who had post EOT viremia that did not correlate with treatment failure.

**Methods.** We reviewed data of patients with HCV/HIV co-infections treated with ledipasvir/sofosbuvir and post EOT viremia. Viral load was detected using Roche Second-Generation Cobas AmpliPrep/Cobas TaqMan which has high sensitivity and specificity with no reported cross-reactivity.

**Results.** Over the course of two years, we treated a total of 112 HCV/HIV co-infected patients. Four patients had EOT viremia (3.5%). During post-EOT HCV VL monitoring single episodes of HCV viremia (157–451 IU/mL) were detected at 4-14 weeks post-EOT. All occurrences were preceded and followed by at least one undetectable HCV VL.

All patients reported excellent adherence to HCV therapy (pill count and patient report) except for one patient who missed two weeks of therapy. All patients had absolute CD4+ cell count >250 cells/mm³.

**Conclusion.** While the literature demonstrates that patients of AA background have lower rates of SVR12, our data states that there was no statistical difference when looking at race and outcome: Limitations in our study included a smaller population, as well as a significantly population that was lost to follow up.

**Disclosures.** Y. Bennani, Gilead: Investigator, Grant recipient; G. Therapondos, Gilead: Investigator and Scientific Advisor, Consulting fee and Research support; C. Parsons, Gilead: Investigator, Grant recipient

2232. Eliminating HCV co-infection in HIV: A Positive Health Clinic (PHC) Venture

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**Background.** HIV/HCV co-infected patients have a higher risk of liver disease and mortality compared to HIV-uninfected patients. While the literature demonstrates that patients of AA background have lower rates of SVR12, our data states that there was no statistical difference when looking at race and outcome: Limitations in our study included a smaller population, as well as a significantly population that was lost to follow up.

**Results.** From January 1, 2014 to April 30, 2017, a total of 71 (12 F 59 M; 35 AA/1 H/35 W; Risk: 38 VDU/31 MSM) HCV/HIV co-infections were identified (GT1: 57; GT3: 6; GT4: 1) with median age of 52 years (range: 21–73). Among them, 21 had fibrosis scores ≥ 3 and 22 < 3. Of 43 patients, 38 completed DAA (test of cure: 34) and 5 are currently on therapy. Lengths of treatment were 8 weeks (4), 12 weeks (30), 16 weeks (1) and 24 weeks (3). All patients had undetectable HCV viral loads at end of treatment (EOT) and test of cure (TOC) visits. Owing to our clinic staff members’ persistent efforts, 5 patients remained adherent to therapy despite having medical events requiring inpatient admission. One patient skipped 7 days of therapy (D22-D28) but still achieved undetectable levels at the EOT and TOC. Among those who had not received DAA (28), 5 died (AIDS:1, Malignancy:2, ESRD:2, Liver disease:1), 3 patients cleared the HCV virus without DAA; 4 incarcerated, and 3 lost to care. Other barriers to therapy included Fibrosure <2 (week 12), <3 (week 16), and 3 lost to care. Among our cohort, we identified patients with the highest HCV viral load (VL) and critical need for therapy. Despite the effective treatments, only a small proportion of co-infected patients achieved SVR12 or treatment failure. Furthermore, we recommend a repeat test in at least 4 weeks of detectable HCV VL to justify any future treatment decisions.

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2233. Barriers to Hepatitis C Treatment in HIV co-infected Patients in the Era of New Direct-Acting Antiviral Therapy

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**Background.** Hepatitis C virus (HCV) infection disproportionately affects HIV-infected patients. Co-infected patients have worse prognoses than mono-infected patients. Despite the effective treatments, only a small proportion of co-infected patients achieve SVR12 or treatment failure. Furthermore, we recommend a repeat test in at least 4 weeks of detectable HCV VL to justify any future treatment decisions.

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

Table 1. Hepatitis C RNA Viral Load Monitoring

| Baseline HCV VL (IU/mL) | Week 4 HCV VL | End of Treatment HCV VL | Post Treatment HCV VL (Weeks after EOT) | Retest Post Treatment HCV VL (Weeks after EOT) |
|-------------------------|--------------|------------------------|----------------------------------------|-----------------------------------------------|
| Patient #1               |              |                        |                                        |                                               |
| 4,534,542 <15           | Not detected | 157 IU/mL (week 14)    | Not detected                           |                                               |
| Patient #2               |              |                        |                                        |                                               |
| 5,916,672 <15           | Not detected | 978 IU/mL (week 4)     | Not detected                           |                                               |
| Patient #3               |              |                        |                                        |                                               |
| 930,145 <15             | Not detected | 257 IU/mL (week 28)    | Not detected                           |                                               |
| Patient #4               |              |                        |                                        |                                               |
| 6,415,450               | Not detected | 4,511 IU/mL (week 16)  | Not detected                           |                                               |

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S660 • OFID 2017:4 (Suppl 1) • Poster Abstracts
patients are treated for HCV infection. This study aims to describe barriers to hepatitis C treatment in HIV/HCV co-infected patients.

Methods. We performed a retrospective observational study of HIV/HCV co-infected patients seen at an urban HIV clinic in the year of 2016 at Drexel University, Philadelphia, PA. We compared patients who were treated for HCV infection vs. those who were untreated. We described demographics and barriers-to-care associated with untreated HCV infection.

Results. Among 1322 patients seen, 112 patients had chronic HCV infection. The median age was 54 (IQR: 48–58) years old and two-thirds (78.6%) were African-American. Medical NTTD counts were 515 (354–750). 85% had controlled viremia (VL < 200 copies) and 43 (44.3%) had fibrosis scores above F3. Sixty were treated for chronic HCV. Among the 55 untreated patients, 20 (36.4%) were in the process of evaluation, 11 (20%) had uncontrolled HIV viremia (HIV viral load >200 copies) and 9 (16.4%) were actively using illicit substances. In HCV treated vs. untreated patients, it was more common to have an undetectable viral load (60% vs. 40%); CD count > 200 (58% vs. 42%); and absence of cocaine abuse (58% vs. 42%). Patients who completed HCV treatment had a higher rate of HCC screening (62% vs 33%, P = 0.005).

Conclusion. Despite the availability of effective DAA therapy, only one half of co-infected patients were treated for HCV. The significant barriers in the delay of HCV treatment were uncontrolled HIV viremia and substance abuse. To overcome these barriers, we suggest: (1) providing support and resources to help patients cease cocaine and other substances; (2) providing HCC screening in HIV patients. This will improve access to treatment, decrease mortality, and improve the quality of life for this patient group.

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2234. Real World Experience of Sofosbuvir/Ledipasvir Therapy in HIV Patients Co-infected with HCV: A Retrospective Study

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Session: 245. HIV and HCV Saturday, October 7, 2017: 12:30 PM

Background. Direct acting antiretrovirals in clinical trials have high efficacy achieving sustained virologic response (SVR) in Hepatitis C virus (HCV) and human-immunodeficiency virus (HIV) co-infected patients. We aim to investigate real-world HCV SVR outcome of ledipasvir/sofosbuvir therapy in the HIV population.

Methods. We performed a retrospective chart review from 2014 to 2016 of patients with HIV/HCV coinfection who received ledipasvir/sofosbuvir in a free-standing HIV clinic. Demographics, data collected included: HCV genotype (Gt), Fib-4 score, length of therapy (LOT), HIV viral load (VL), CD4+ cell count, antiretroviral therapy (ART), HCV RNA levels at baseline, 4 weeks, 8 weeks, end of therapy (EOT), and SVR at week 12 post-treatment. Statistical analysis was performed using Stata version 14 (STATA Corp., Texas, USA).

Results. A total of 94 patients were included. The mean age was 54 years-old, 78% were male. Most patients (95%) had Gt 1 HCV infection (84% 1A, 11% 1B and 1% mixed), 4% Gt 4, and one patient had Gt 6; 24% of patients had compensated cirrhosis. Median LOT was 12 weeks. 95% of patients received 12 weeks, 4% 24 weeks, and 1% received 16 weeks of therapy. Most patients had undetectable HIV VL (77% with <20 copies/mL), while 23% had HIV VL range from 20 to 1,430 copies/mL. The mean CD4+ count was 659 cells/μl (59% Gt 567–711). The most commonly used ARTs were efavirenz/emtricitabine/tenofovir (21%), followed by abacavir/dolutegravir/tenofovir (16%). PEG-IFN/RBV was used in 1% of the patients. SVR was achieved in 93% (93/99) of patients (100% in HCV Gt 1 infected patients), 1% mixed), 4% Gt 4, and one patient had Gt 6; 24% of patients had compensated cirrhosis.

Conclusion. Our HCV real-life experience with ledipasvir/sofosbuvir at a free-standing HIV clinic confirms the efficacy and safety reported in randomized clinical trials. NS5A mutation led to treatment failure in this heterogeneous group of patients.

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2235. Hepatitis C and HIV Primary Care Screening Intervention Increases Identification and Linkage to Care within a Large Healthcare system

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Session: 245. HIV and HCV Saturday, October 7, 2017: 12:30 PM

Background. Societal and economic burdens of hepatitis C virus (HCV) and human immunodeficiency virus (HIV) continue to grow. The CDC recommends a one-time HCV screen for individuals in the Baby Boomer population (those born between 1945 and 1965) and a one-time HIV screen for all individuals between ages 13–64, with more frequent screening for both conditions based on individual risk factors.

Methods. A system-wide electronic medical record alert prompting HCV screening was implemented in May 2016 targeting the Baby Boomer population. In addition to the system alert, an educational program detailing disease epidemiology, screening recommendations, and algorithms to guide screening efforts was developed by a quality improvement team to increase HCV and HIV screening and linkage to care for positive patients. Carolinas HealthCare System (CHS) is a nonprofit, vertically integrated healthcare system with approximately 12 million patient encounters per year. Twelve primary care practices, including 5 safety-net practices serving predominantly Medicaid and uninsured patients, with total of 43,000 patients born between 1945 and 1965 were selected for the educational intervention.

Results. Prior to the system-wide HCV alert, from May-December 2015, 2430 patients were screened for Hepatitis C; one year later post HCV alert (from May-December 2016), 8872 patients were screened, resulting in a 350% increase in screening. Chi-squared analysis comparing the percentage of patients tested between the two-time periods was significantly different (P < 0.001). For the educational intervention (P = 0.001).

Conclusion. EMR modifications and provider education along with availability of connect to care partners within a large, integrated, healthcare system can significantly enhance screening and care for patients with HCV and HIV. Innovative interventions are needed to improve screening rates and link positive patients into care.

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2236. Viral Hepatitis among HIV+ Patients in Northern Vietnam

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Background. Liver disease due to hepatitis B (HBV) and hepatitis C (HCV) is becoming the largest cause of death in HIV+ individuals worldwide. Compared with its neighbors, Vietnam has been identified as a country where coinfection with viral hepatitis among HIV+ persons is especially high, concentrated in people who inject drugs (PWID). The aim of this project was to investigate hepatitis prevalence among HIV+ patients at four medical facilities in northern Vietnam.

Methods. We conducted a retrospective chart review among HIV+ patients beginning ART between 2012 and 2015 at Bach Mai Hospital and the National Hospital for Tropical Diseases (NHTD) in Hanoi, and the Pho Yen and Thai Nguyen City Health Centers in Thai Nguyen Province. Collected data included demographics, history of injection drug use, and testing and treatment status for HBV and HCV. A missing test result counted as a negative result for calculation of prevalence.

Results. 979 patient charts were examined (Bach Mai, n = 522; NHTD, n = 200; Pho Yen, n = 91; Thai Nguyen, n = 166). Across all four sites, prevalence of HCV coinfection ranged from 26% to 36%, HBV coinfection ranged from 5% to 7%, and HCV/HBV coinfection ranged from 4% to 8%. At Bach Mai and NHTD, PWID were ~50% of the HCV coinfected group and nearly 60% of the HCV/HBV dually coinfected group. As first line treatment for HBV was the same as ART, all patients with HBV were already being treated for it. HCV treatment was limited, with Bach Mai Hospital being the only site that had evidence of treatment. At Bach Mai, 3% of HIV patients coinfected with HCV only and 2% of HIV patients with both HCV/HBV received treatment for their HCV. Pegylated interferon+ribavirin was the only regimen used.

Conclusions. Compared with the general Vietnamese population, HCV was more prevalent among our sample of HIV+ individuals. As missing results were counted as negatives, it is likely that the true prevalence rates of both HCV and HBV are higher than reported. The lack of treatment for HCV among coinfected HIV+ individuals was concerning, particularly given the morbidity of HCV coinfection, and is an area for future intervention. Given the large percentage of HCV coinfected patients that were PWID, future efforts for the prevention and treatment of HCV should be focused in this community.

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2237. Relationship of Risk Screening to HIV and Viral Hepatitis Detection for Participants in a Colorado Narcotic Replacement Therapy Program

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