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 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 for statin therapy. Only 44% of patients 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. Yeltman, Janssen: Speaker’s Bureau, Speaker honorarium.

2255. Fibroblast Growth Factor 23, a Potential Risk Factor for Cardiovascular disease

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Background. Fibroblast Growth Factor 23, a Potential Risk Factor for Cardiovascular disease due to smoking are 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 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: among Hispanic, had lower total cholesterol (P = 0.040). AA patients had lower triglycerides (< 0.001), and White patients had higher triglycerides (< 0.001). HDL levels were higher in AA patients and lowest in White patients (P < 0.001), while Hispanics had lower LDL values (P-value 0.009). There was no statistically significant (P > 0.05) difference between lipid lowering drug (LLD) regimens 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). The 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 minority necessitate further investigation to close the gaps in care and improve our management of dyslipidemia for our HIV patients.

Disclosures. All authors: No reported disclosures.