Baseline Characteristics	2	3	4
	HCV/HIV Cirrhosis (n = 10)	HCV/HIV no Cirrhosis (n = 22)	HCV Cirrhosis (n = 28)	p value
Gender, n (%)				0.14
Male	9 (90)	20 (91)	19 (70)	
Female	1 (10)	2 (9)	8 (30)	
Ethnicity, n (%)				0.41
Caucasian	4 (40)	7 (32)	14 (54)	
African American	2 (20)	6 (27)	3 (12)	
Hispanic	4 (40)	9. (41)	7 (27)	
Unknown	0	0	2 (7)	
Age (years), mean (SD)	55 (9.76)	55 (7.02)	59 (9.76)	0.42
Diabetes mellitus, n (%)	4 (40)	1 (5)	7 (25)	0.04
CKD, n (%)	3 (30)	4 (18)	3 (11)	0.36
History of Alcoholism, n (%)	4 (40)	3 (14)	10 (36)	0.15
History of IVDU, n (%)	5 (50)	12 (56)	16 (57)	0.36
Childs Score, n (%)				0.12
A	6 (75)	17 (100)	22 (81)	
B	2 (25)	0	5 (19)	
Genotype , n (%)				0.66
1	7 (70)	18 (82)	22 (82)	
2	1 (10)	0	2 (7)	
3	2 (20)	3 (14)	3 (11)	
4	0	1 (4)	0	0

Bivariate analysis SVR	.	.	
	SVR = no	SVR= yes	p value
Cirrhosis, n (%)	3 (100)	35 (61)	0.29
HIV, n (%)	1 (33.3)	31 (54.4)	0.59
CD4 < 200, n (%)	0	3 (10)	1
HIV VL detected, n (%)	2 (22)	5 (16)	0.61
ART change prior to HCV treatment, n (%)	0	7(22)	0.65
Prior HCV tx with DAA, n (%)	0	3 (5)	1
Prior HCV tx non-DAA, n (%)	0	12 (21)	1

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355. Barriers for Hepatitis C Elimination in HIV/HCV Coinfected Patients

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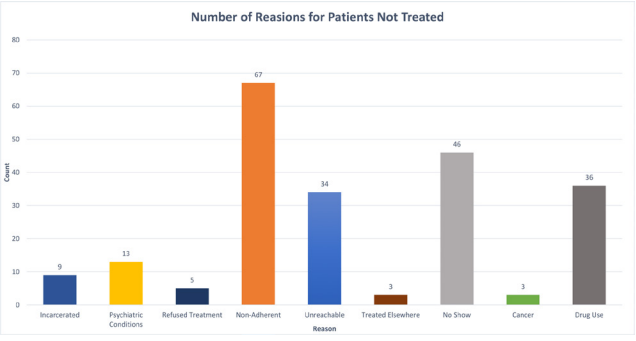
Session: 45. HIV Complications: Hepatitis Co-Infections
Thursday, October 3, 2019: 12:15 PM

Background. Approximately 30% of people living with HIV are co-infected with Hepatitis C virus (HCV). HIV/HCV coinfected patients have faster progression to liver fibrosis, cirrhosis, and increased mortality, compared with monoinfected patients. Therefore, treatment in this population is a priority. The objective of this study was to develop an active program to reach HIV/HCV co-infected patients, with the goal to eliminate Hepatitis C in our local HIV clinic.

Methods. Beginning in December 2016, our clinic received State funds to support open access to treat HIV/HCV patients with direct-acting antivirals (DAA). From December 2016 to May 2018, the process was based on primarily on physician referrals to treat HIV/HCV patients at our clinic, without an active intervention, and 50 patients were treated. Our active intervention during the second part was based on the identification of all untreated HIV/HCV patients and contacting them directly, to link them to care.

Results. A total of 462 HIV/HCV co-infected patients were identified who qualified for the state-sponsored treatment program. From June 1, 2018 to July 31, 2018, only 7 patients were linked to care and started on DAA. The four main identified reasons for not getting DAA therapy were: no show up to the clinic appointments, poor adherence to their HIV antiretroviral treatment, use of drugs and not able to be reached (figure). Although drug use was listed as one of the main reasons for not receiving DAA therapy, it was not the defining reason for most patients. A majority of the patients had more than one obstacle preventing them from coming in to be treated.

Conclusion. Wide availability of DAA and open access to treatment is not enough to eliminate HIV/HCV co-infection. Innovative outreach processes with the active participation of key stakeholders are needed in order to eliminate this viral infection.



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356. HIV-HCV Coinfection: An Investigation of CD4 T-Cell Reconstitution after HCV Direct-Acting Antiviral Treatment

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Background. Both human immunodeficiency virus (HIV) and hepatitis C virus (HCV) can adversely affect CD4 cell count. Among patients with HIV-HCV coinfection, treatment with HCV direct-acting antivirals (DAAs) may be an opportunity to restore/reconstitute CD4 count. The primary objective of this study was to determine whether DAA treatment results in improved CD4 cell counts in HIV-HCV coinfected patients.

Methods. A retrospective multicenter cohort study was performed among 4 sites between 11/1/2013–4/12/2018. Patients were included if they were age ≥18 years, infected with both HIV and HCV, and received all-oral DAA therapy. Trained reviewers extracted demographics, comorbidities, receipt of antiretroviral therapy (ART), DAA treatment regimen/duration and HIV/HCV-related lab values, which included CD4, HIV RNA, and HCV RNA. Labs were restricted to the closest values before/after DAA treatment. The primary endpoint was changed in pre-DAA/post-DAA CD4 count. Descriptive statistic and Wilcoxan Signed Rank were used.

Results. There were 88 patients included. Most (78.4%) identified as male. Mean ± standard deviation (SD) age was 57.1 ± 9.6 years. The proportion of patients with undetectable pretreatment HIV RNA was 78.4%. Among the 97.7% of patients on ART, regimens included the following classes of ART: integrase strand transfer inhibitor (75.6%), non-nucleoside reverse transcriptase inhibitors (23.3%) and protease inhibitors (19.8%). Of the 87 patients who completed DAA therapy and had post-DAA labs drawn, sustained virologic response (SVR) was achieved in 96.6%. The median (interquartile range, IQR) CD4 counts before/after DAA treatment did not significantly differ [515 (349–704) vs. 554 (374–693), $P = 0.80$]. In the subset of patients with pre-DAA CD4 counts < 350 cells/mm^3 (n = 23), CD4 count significantly improved before/after DAA treatment [235 (202–311) vs. 309 (189–392), $P = 0.01$].

Conclusion. The use of DAA therapy in HIV-HCV co-infected patients resulted in a significant increase in CD4 count in patients with pre-DAA CD4 < 350 cells/mm^3. This may represent a high priority population for DAA treatment.

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

357. Hepatitis C (HCV) Testing and Diagnosis and Their Relationship to Sexually Transmitted Infection (STI) Screening and New Infections in an HIV+ Men Who Have Sex with Men (MSM) Outpatient Cohort

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Background. Assess HCV prevalence, screening, new infections and reinfections and their relationship to other STI screening and diagnosis in HIV+ MSM at an urban center.

Methods. Retrospective review of HCV and STI testing and diagnosis among HIV+ MSM with ≥1 visit January 1, 2016–October 31, 2018 at Montefiore's Center for Positive Living and Medical Group outpatient sites. Demographics from local databases, clinical data from EPIC and chart review on select cases.

Results. 876 HIV+ MSM, median age 42, 80% virally suppressed. 850 (98.2%) had known HCV status. 36/850 (4.2%) HCV Antibody (Ab)+ at any point: 23 (2.7%) at baseline (6 dual MSM/IDU), 13 (1.5%) newly Ab+ (0 dual risk). 4/36 (11.1%) HCV RNA+: 1 of baseline Ab+, 3 in newly Ab+'s. Among new Ab+'s, 7 asymptomatic, 6 symptomatic, most commonly high liver tests. 3/13 (15.4%) were persistently viremic requiring therapy. 614/827 (74.2%) HCV Ab-'s were retested ≥1, 260 (31.4%) >1x – average retesting interval 13 months. Among 36 HCV Ab+'s, 0 had reinfection. Testing and new STIs by HCV status is in Table 1. 2/13 (15.4%) with new HCV were not tested for gonorrhea or chlamydia (G/C) at any site. Acute syphilis was more common in new HCV+'s than HCV-'s ($P = .002$). HCV rescreening was higher in those tested for extragenital (EG) G/C vs. those not tested (Table 2), but up to 18.8% were not HCV retested despite EG testing done. 304/876 (34.7%) were ≤35 years of age. Testing and positive results for all four STIs were greater in those ≤35 (Table 3). Non-Hispanic (NH)-Black was the largest race/ethnicity and had the highest rate of new STI's except pharyngeal chlamydia, rectal gonorrhea and acute syphilis (Table 4).

Conclusion. We found significant risk of HCV among HIV+ MSM in our cohort, with a prevalence of 2.7% and a 34-month incidence of 1.5%, with no reinfections. HIV+/HCV Ab- MSM were frequently retested for HCV but missed opportunities among sexually active individuals lead to delayed diagnoses of acute infection. Unexplained elevation of liver tests in sexually active HIV+ MSM should prompt immediate HCV testing, and more HCV Ab testing is indicated as part of STI screening in this group. Awareness should be raised about risk of acute HCV with new syphilis, and there is room to improve EG G/C testing.